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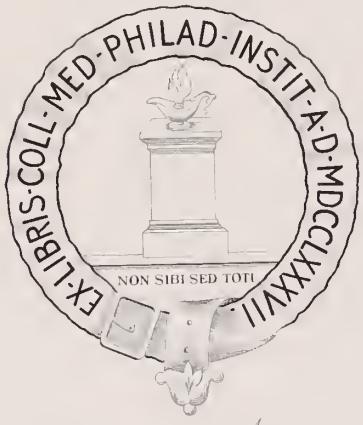

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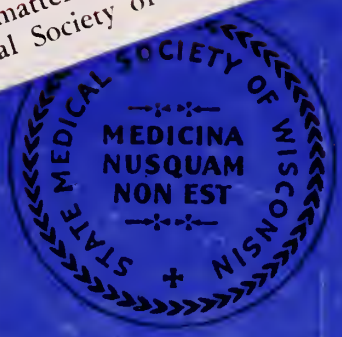

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents Clinical Practice."

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rnings: Age, weight, dosage, duration of therapy, ex- ence of concomitant diseases, and concurrent potent emotherapy affect incidence of toxic reactions. Care- y instruct and observe the individual patient, espe- lly the aging (forty years and over) who have reased susceptibility to the toxicity of the drug. Use vest effective dosage. Weigh initially unpredictable nefits against potential risk of severe, even fatal, re- ions. The disease condition itself is unaltered by the g. Use with caution in first trimester of pregnancy d in nursing mothers. Drug may appear in cord blood d breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

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OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of Article XIII of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the May 1972 annual session of the House of Delegates, are being published in the January and February, 1973, issues of the WISCONSIN MEDICAL JOURNAL, prior to House of Delegates' action at the March 1973 annual session.

* * *

Society's Purpose Clause: Amend Article II entitled "Purpose" as follows:

In the first and second lines of Article II delete the words "federate and".

In the tenth line delete "to promote friendly intercourse" and substitute "to promote open communication and understanding".

Therefore, Article II would then read: The Purposes of this Society shall be to bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

Election of Councilors: Amend Article IX entitled "Officers" as follows:

Delete the second paragraph which now reads: "Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated." Re-create the second paragraph of Article IX to read: "Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the confirmation of the House of Delegates."

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PRESIDENT'S PAGE

The One Voice of Medicine

President Harry S. Truman was asked upon leaving his office in 1952 just what he considered his greatest disappointment as president. He quickly replied his failure to have enacted into law some form of national health insurance.

Ever since then, medical care and plans for a federal form of health care have attracted the attention of politicians, social planners, and the press. Lyndon B. Johnson succeeded in enacting the Medicare and Medicaid amendments to the Social Security laws, together with the development of regional medical plans and the comprehensive area health planning legislation, all in the year 1965. Organized medicine at all levels is now deeply involved in the delivery of these forms of federal action.

Medicine in 1973 must now meet and abide by the amendments embodied in H. R. 1, signed into law by President Nixon on October 30, 1972. These amendments, incidentally, will have a far greater impact upon medical care than did the 1965 Johnson legislation.

Senators and congressmen alike are now confidently forecasting some sort of national health insurance by 1974. Consumerism is in the air, labor unions are now stipulating what constitutes good medical care in attempting to control its costs. The press, radio, and TV have belabored medicine and the rising costs of medical care. Only a few have lent praise to the excellence of today's medical care and the unparalleled progress of medicine.

All this leads to the question, "Who should speak for medicine?" I am convinced that the local county medical society, working in close concert with the state medical society, must serve as the one strong voice of medicine. The matrix of a strong county or state medical society must be individual physician member input. The society will not function by itself. Motivated, selfless hard work must follow its every step.

I would urge each of our component county medical societies to review their membership roster of physicians. We need the total voice of all practicing physicians. Appeal to non-member physicians to join and participate in local and state medical society affairs. The State Medical Society of Wisconsin delegates to the American Medical Association may then truly and completely represent Wisconsin medicine.

Each physician in practice has a moral and medical obligation to join with his brother physicians through his medical society so that the one voice of medicine may serve as a guiding hand to the fateful deliberations that so surely lie before us.

Robert F. Purtell MD

Robert F. Purtell, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Transition—last of a series

MEDICINE, NO LESS than any other profession, stands on the brink of something entirely new. Not that our specific skills will change much, although this is not to negate research discoveries and new techniques of diagnosis and treatment. These are grand, and proliferating. But to ride the changing currents of the stream of human demands may well require something different.

Some parts of this present pivot point in history have been discussed in the first four editorials. Now it is time to look at what we must do, and what we can do to stay on top of the rapid developments in our complex society, regardless of which political party holds sway in any given decade. What is needed is some system to analyze the changing social patterns *before* they become political realities. To wait until the political denouement could be to expose ourselves to final and perhaps fatal positions.

To learn about this we must move our eyes (but not ourselves) away from the day by day routine of patient care, no matter how satisfying that may be, or how satisfactory it seems to us and to our patients, for new institutions are forming before our very eyes. Hospital-based practice will be the wave of the future, say some. Others desert the hospital structure and look to HMOs as the nucleus of the future practice of medicine, with hospitals being secondary. Others, trained in different social spheres than we are, believe some yet unformed sort of larger institutional control, perhaps a new form of federal structure, will simply dominate both of these suggested forms. I cannot know, nor can any of us. But we can open our eyes and ears and think, not in disease patterns, but in social patterns.

This does not mean we have to identify the tide of some one or another system and hie to it. That would be predictive all right, but not integrative. I believe we are still in a stage where a systematic organization of our intelligence can be used to help us arrive at an adequate and intelligent system of organizing ourselves. No one profession has, yet, a monopoly on this skill. There are many who try—professional communicators, sociologists, historians, bureau-oriented fellows, and the like. I saw much of this during my active years in the U.S.P.H.S.; and while their intent was generally good, the accuracy of their aim was often doubtful.

It seems to me that physicians, as a group, bathed as we are in day by day patient contact, could learn more than any research or institutional group about human needs, as they now become a conscious part of our daily life, and of political life therefore. Some bureaus, or institutions, may even have lost the power to read accurately what human needs are, dominated rather by some general or idealistic thesis. Doctors need not do this, but need only to listen to their patients. Admittedly this may be difficult, but it can be fulfilling, and may help us anticipate our future.

Now to be aware of human need does not at all mean the same thing as to satisfy all demands. Some demands are irrational and must be managed by the physician as just that. For example, the human need to be saved from death by cancer cannot, as yet, be met although it is most real. But we can do much to prevent it, to ease the burden, and most of all to set up means to manage the fear that goes with it. Sometimes patients form their own groups for this purpose, as with alcoholism, diabetes, obesity, and other sorts of common human problems.

Medical comprehension should be superior to lay groups in sensing and meeting this sort of need. Or shall the tail wag the dog, as with the current Task Force recommendation that neither physicians nor their psychiatric brethren have done more than confuse the issue of the alcoholic!

There are several shifts needed in our perspectives if we are to do all this. It is most complicated, I'll admit, yet we must try. First off, we must assume a more active role in information interpretation. In Milwaukee County this is done in several ways, not the least of which has been the publication of the weekly "Ask the Doctor" column in our *Milwaukee Journal* (the newspaper, not the *Medical Times*). In doing this over the past two years, I learned from the letters more about our failures to communicate than I learned about medicine. For various reasons I no longer do this, but this kind of public contact both teaches us, and gives us a chance to present our view to some parts of the . . . (reading) . . . public. Then, we can cast our eyes into more futuristic positions. This is not done overnight, and it certainly is *not* done by violently holding onto the present, or passively giving in to any scheme that seems to come along. The various political action groups, e.g., the key men idea, move in this direction. We can move into forecasting the future of social change and behavior if we use our knowledge learned, not in medical school but in practice. This can put us well ahead of the merely technical communicators and theorists—hopefully.

A fourth possible shift in our perspectives is toward a tolerance for ambiguity. We are used to doubt and the unknown, better than most, when we face our patients and their families. But can we turn our antenna toward more subtle conflicts and ambiguities in the changing world? We face, not only in medicine but also in other parts of our lives, discrepancy of information, surges of partly formed schemes for new institutions (or bureaus), uncertainty even about direction (although any one prophet certainly does not sound uncertain), and many new life styles, value systems and conflicts.

All of these things demand that we as doctors, if we are really to take part in the "brave new world," become aware of such broad issues as human values, ecology, privacy, and so on. If not, we can be smothered in some sort of Orwellian dehumanization. But the potential is there for us to make something better than that. One aspect of this struggle is words, even like these words here. But even if my insights are accurate, they are of no more value to us without action than a map will get you to some other city, or psychological insight alone will change established patterns of behavior.—RH □

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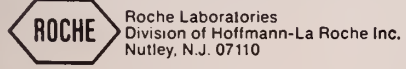

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

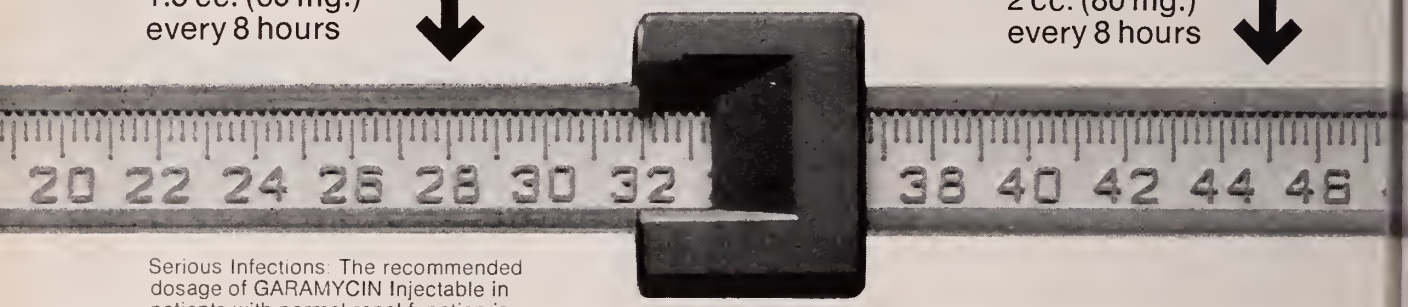
In serious gram-negative infections*

Simplified dosage guidelines

Usual adult dosage - - I.M. and I.V. - - in patients with normal renal function

132 lbs. or less
1.5 cc. (60 mg.)
every 8 hours

Over 132 lbs.
2 cc. (80 mg.)
every 8 hours



Serious Infections: The recommended dosage of GARAMYCIN Injectable in patients with normal renal function is 3 mg./kg./day administered in three equal doses every 8 hours.

Life-Threatening Infections: Dosages of up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

Children's Dosage—I.M. and I.V.
3 to 5 mg./kg./day in three equal doses every 8 hours.

*Due to susceptible organisms

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly stre-

Schering

Garamycin®

gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Duration of therapy–I.M. and I.V.

The usual duration of treatment is 7 to 10 days. In difficult and complicated infections, a longer course of therapy may be necessary.

Instructions for I.V. use

Dilution—A single dose is diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution should not exceed 1 mg./cc. (0.1%).

Infusion time—The solution is infused over a period of 1 to 2 hours.

Premixing—GARAMYCIN Injectable should not be physically premixed with other drugs but should be administered separately in accordance with the recommended route of administration and dosage schedule.

In adults with impaired renal function

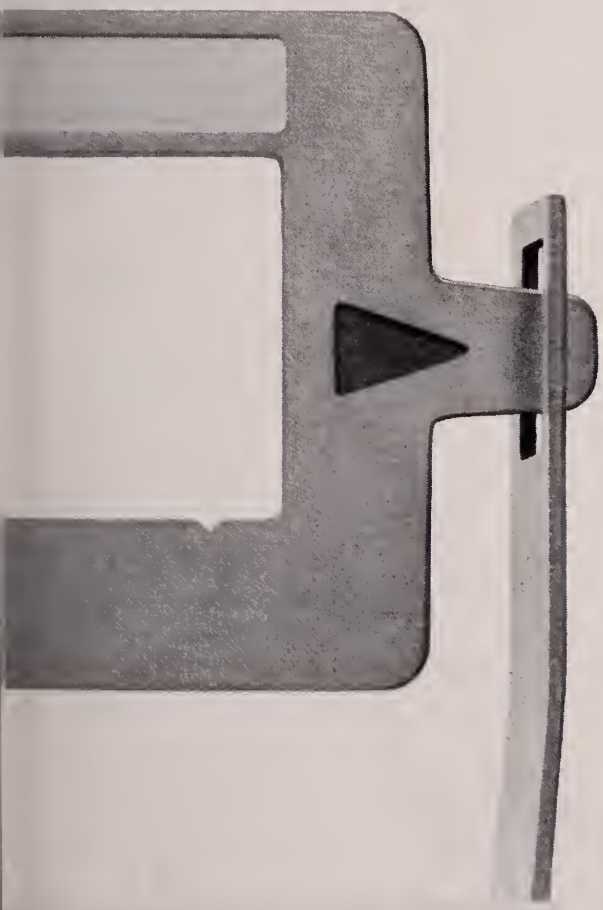
The single dose of GARAMYCIN Injectable given by patient weight remains the same; however, the interval between doses must be extended.

This interval may be approximated by multiplying the serum creatinine by eight as follows:

Serum creatinine $\times$ 8 = frequency of administration
(mg./100 ml.) (in hours)

This dosage schedule is not intended as a rigid recommendation, but is provided as a guide to dosage when the measurement of gentamicin serum levels is not feasible.

See Clinical Considerations section which follows...



ycin, neomycin, kanamycin, cephaloridine, omycin, polymyxin B, and polymyxin E olistin), should be avoided.
The concurrent use of gentamicin with pontdiuretics should be avoided, since certain uretics by themselves may cause ototoxic-. In addition, when administered intraveously, diuretics may cause a rise in gentamin serum level and potentiate neurotoxicity.
SAGE IN PREGNANCY Safety for use pregnancy has not been established.

Schering

Garamycin® Injectable
brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING: Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause toxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration. APRIL, 1972

AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033. SLR-192

Garamycin®
gentamicin sulfate injectable
I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

SECTION OPHTHALMOLOGY

JANUARY 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

CURRENT CONCEPTS IN MANAGEMENT OF CORNEAL DISEASE

I. TREATMENT OF HERPETIC KERATITIS WITH ADENINE ARABINOSIDE

An exciting new antiviral drug—adenine arabinoside (ARA–A)—recently has been made available to us. Work in animals and humans with herpetic keratitis has indicated that it is a drug which may be an excellent alternative to iododeoxyurine (IDU) since it is effective against IDU-resistant virus, maintains its antiviral activity much longer than IDU does after a dose, and is reported to penetrate corneal stroma better than IDU.

Clinical trials are now being conducted with ARA–A at the Medical College of Wisconsin in patients with untreated dendritic herpetic lesions, and also a study on cases of herpetic keratitis that have not responded to IDU. The results so far are very encouraging. No toxicity has been demonstrated either by us or in similar studies that are ongoing in Boston, Philadelphia, Michigan, and Texas.

II. THERAPEUTIC HYDROPHILIC CONTACT LENSES

Therapeutic hydrophilic contact lenses are not officially approved as of yet for general therapeutic use but recent investigations by us and other therapeutic investigators indicate that these lenses may benefit patients with a number of corneal conditions.

Their use generally parallels that of the epikeratoprosthesis, but the hydrophilic lenses are superior in that they can be worn according to a schedule, they aid in delivering certain medications, they are much better tolerated, they can be used if Bowman's membrane is damaged, and are helpful therapeutically in themselves because of their bandage effect.

We have used the therapeutic Soflens® (Bausch and Lomb) in a variety of corneal problems and believe that the following outline is a helpful guide for their applications:

1. Corneal edema—bullous keratopathy (for pain or vision)
2. Indolent corneal ulcers
3. Recurrent corneal erosions
4. Dry eye syndromes
5. Corneal scarring (surface problems, to correct irregular astigmatism)
6. Keratoconus (to correct irregular astigmatism)
7. Miscellaneous
   a. Filamentary keratitis
   b. Lid abnormalities and trichiasis
   c. Burns
   d. Abrasions
   e. After keratoplasty

Details on their use in these conditions including rationale, problems to watch for, and their efficacy were discussed.

III. FUNGAL KERATITIS—DIAGNOSIS AND MANAGEMENT

Fungal keratitis has been reported previously from mainly the southern states, but in the last 18 months we have treated five patients with culturally proven fungal corneal ulcers in Milwaukee. Two of the cases were caused by *Candida,* and one each was caused by *Aspergillus, Penicillium,* and *Alternaria* species.

Clinical features in the history that should make one suggest a fungal ulcer were reviewed. Characteristics of the ulcer itself that may be helpful in diagnosis were presented, and the laboratory workup of these ulcers was discussed.

There are a number of antifungal agents that can be used in the treatment of fungal keratitis. The most promising of these that we have had favorable clinical experience with recently is a new antifungal drug—pimaricin. It has been used as a 5% suspension topically and has a broad antifungal spectrum. We are currently evaluating a new antifungal drug, clotrimazole, *in vitro,* and find it has a wide spectrum and is more potent *in vitro* than either pimaricin, amphotericin B, or nystatin.

A surgical approach to keratomycosis must be considered when medical therapy has failed. There is no one single approach, but penetrating keratoplasty may be necessary if the lesion is deep, and it can be covered by an 8 mm trephine. Lamellar keratoplasty is contraindicated since the cornea is often invaded deeply and considerably beyond the area visibly involved and the lamellar becomes involved. A conjunctival flap may be useful in large diffuse superficial ulcers. It should be emphasized that repeated debridement and sometimes a keratectomy are useful adjuncts to medical therapy. When an infected fungal ulcer perforates, isobutyl-cyanoacrylate tissue adhesive can be used and was useful in two of our cases to maintain the integrity of the anterior chamber. Complications that may occur in surgical management were discussed.—ROBERT A. HYNDIUK, MD, *Director,* Cornea and External Disease Unit; and Assistant Professor of Ophthalmology, Medical College of Wisconsin, Milwaukee. □

Presented at a meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, October 21, 1972 in Wausau.

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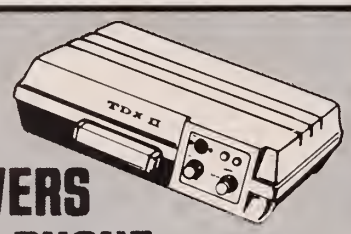

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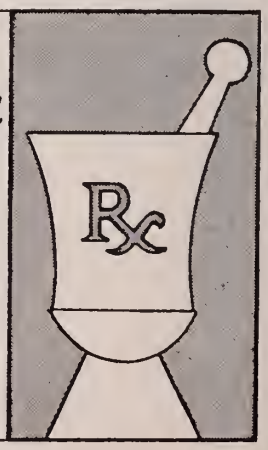

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS JANUARY 1973

Phone/Radio Conferences for Medical Assistants Jan. 10–May 9, 1973

THE COOPERATION of the University of Wisconsin Extension, Department of Postgraduate Medicine, and the Wisconsin Physicians Service has enabled the AAMA, Inc.—Wisconsin Society, to offer the medical assistants in Wisconsin the opportunity to participate in five Telephone/Radio Conferences.

CURRICULUM

JAN. 10: *The Role of the Medical Assistant in HMO*
Speaker will be Mr. Foster O. Rodda of the Group Health of Puget Sound, Seattle, Washington.

FEB. 14: *Colposcopy*
Speaker will be Charles F. Dungar, MD, Appleton, Wisconsin. Doctor Dungar is a Diplomate of the American Board of Obstetrics and Gynecology and a member of the American Society of Colposcopy and Colpomicroscopy. He will prepare the conference in cooperation with Adolf Stafl, MD of the Medical College of Wisconsin, Milwaukee.

MAR. 14: *Attitudes of the Medical Assistant*
Speaker will be Professor Elwood N. Chapman, Ontario, California. Professor Chapman has written a book on *Attitudes* and has spoken frequently on how attitudes are reflected by the action of others.

APR. 11: *Medicolegal Problems Encountered by the Medical Assistant*
Speaker will be H. B. Maroney, Assistant Secretary of the State Medical Society, Madison, Wisconsin. Mr. Maroney will emphasize the laws of the State of Wisconsin that relate to medical practice and questions of the medical assistant.

MAY 9: *Physiological Problems of Aging*
Speaker will be John Nowlin, MD, Center for Study of Aging and Human Development, Duke Medical Center, Durham, North Carolina. Doctor Nowlin was referred to us by Dr. George Maddox, Director of this Study at Duke University, as an expert in this field.

Registration fee for the five Conferences is $12.00. Payable to the University of Wisconsin, Extension Division.

Further information may be obtained from:

ANN JOHNSTON, *Coordinator*
Telephone/Radio Conferences
Department of Postgraduate Medicine
610 Walnut Street
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☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
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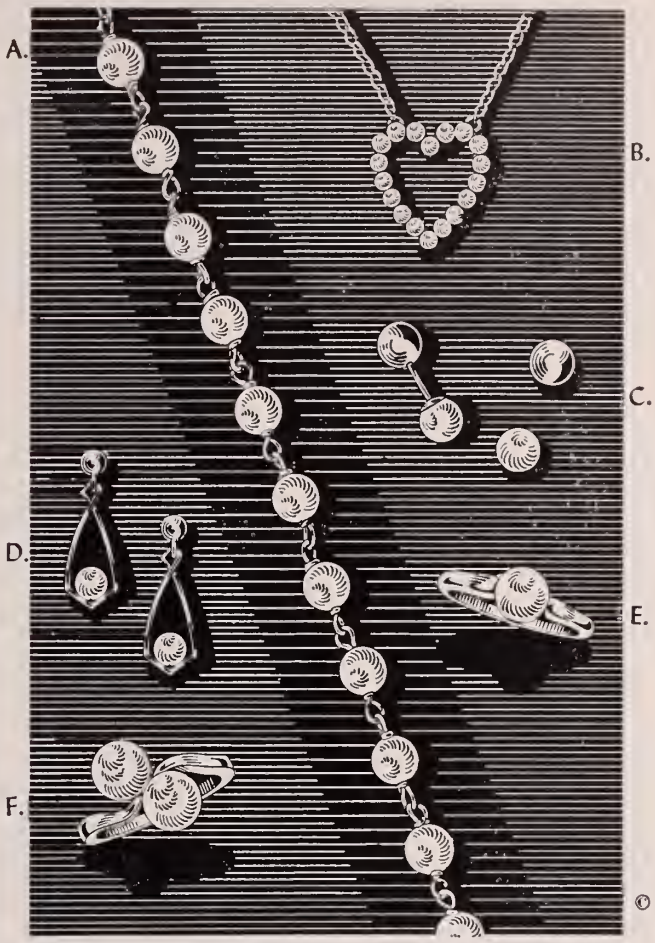
BOYS TOWN INSTITUTE FOR THE STUDY AND TREATMENT OF HEARING AND SPEECH DISORDERS IN CHILDREN has been established in Boys Town, Neb., at a cost of $30 million, it was announced recently by the Most Rev. Daniel E. Sheehan, Archbishop of Omaha and President of the Board of Directors of Father Flanagan's Boys' Home. The project, one of several under consideration for the expansion of the basic concept of Boys Town—service to youth—is expected to become a nationally prominent center for the total rehabilitation of the communicatively disabled child. It is assumed that children with potentially correctible hearing and speech defects will be referred to the Institute from orphanages, other child care facilities and welfare agencies throughout the United States for various periods of intensive rehabilitative therapy. Following the rehabilitative measures at the Institute, the patients would be returned to the referral facility for additional education or possible placement in adoptive homes.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1972

2 Wisconsin College Health Association
5 Steering Committee, Wisconsin Emergency Medical Services Program
5 Dane County Medical Society Board of Trustees
5 Madison General Hospital Surgical Staff
5 Madison Anesthesiology Society
5 Madison Urological Society
7 American Board of Surgery Exams
8 SMS Division on Maternal and Child Welfare
9 SMS Commission on Medical Care Plans
12 Dane County Medical Society
13 SMS Ad Hoc Committee on Chiropractic
14 Executive Committee, Wisconsin Health Care Review, Inc.
14 Permanent Commission to Museum of Medical Progress
15 Medical Advisory Committee, Wisconsin Emergency Medical Services Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.



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C. Convertible earring	$12.00	D. Drop earring	$23.50
E. Single pearl	$21.50	F. Passby style	$24.50

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1. Primary eunuchoidism and eunuchism. **2.** Male climacteric symptoms when these are secondary to androgen deficiency. **3.** Those symptoms of panhypopituitarism related to hypogonadism. **4.** Impotence due to androgen deficiency. **5.** Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.
In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. **2.** Palliation of androgen-responsive, advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.
Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.
Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.
Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive se al stimulation, oligospermia, reduced ejacula y volume, hypersensitivity and gynecomastia ay occur. When any of these effects appear the n-drogen should be stopped.
Adverse Reactions: Acne. Decreased ejacula y volume. Gynecomastia. Edema. Hypersensit y including skin manifestations and anaphylac c reactions. Priapism. Hypercalcemia (especial in immobile patients and those with metastatic br st carcinoma). Virilization in females. Choles ic jaundice.
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– George Sarton, from "The History of Medicine Versus the History of Art"

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Opinion

Results of a questionnaire to 7,000 physicians:

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13.8%
Do not believe combination drug products are useful.

Are combination drug product useful in treatment involvin concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

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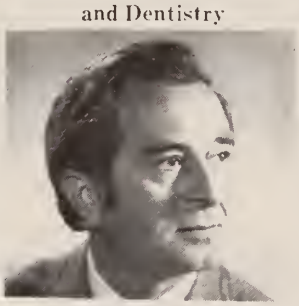

Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great of money. I wish we c agree on a "grandfa clause" approach to pr rations that have been i for a number of years that have an appare satisfactory track recor

For example, I th some of the antibiotic c binations that were ta off the market by the F performed quite well. I thinking particularly penicillin - streptomy combinations that pati —especially surgical tients—were given in injection. This made less discomfort for the tient, less demand nurses' time, and fe opportunities for dos errors. To take suc preparation off the ma doesn't seem to be g medicine, unless actual age showed a great dea harm from the inject (rather than the pro use) of the combinatio

The point that should empbasized is that th are both rational and i tional combinations. real question is, who sho determine which is whi Obviously, the FDA m play a major role in m ing this determination. fact, I don't think it avoid taking the ultim responsibility, but it sho enlist the help of outs physicians and experts assessing the evidence in making the ultimate cision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories

If two medications are sed effectively to treat a rtain condition, and it is nown that they are comatible, it clearly is useful nd convenient to provide iem in one dosage form. would make no sense, in ict it would be pedantic, insist they always be rescribed separately. To void the appearance of edantry, the "expert" deies the combination beiuse it is a fixed dosage rm. When the "expert" vokes the concept of fixed osage form he obscures ie fact that single-ingreent pharmaceutical preprations are also fixed osage forms. By a singular mantic exercise he imies a pejorative meaning the term "fixed dose" ily when he uses it with spect to combinations. hat is ignored is the sime fact that only in the rest of circumstances es any physician attempt titrate an exact therautic response in his paent. It is quite possible at some aches and pains ll respond to 500 mg. of pirin yet that fact does t militate against the *usl* dose being 650 mg.

The other semantic ploy ten called into play is to scribe a combination oduct as rational or irraonal.

Take antibiotic mixtures, e source of much of the ticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
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Volume 72

JANUARY 1973–DECEMBER 1973

A Report of the Governor's Task Force on Health

THIS ISSUE OF THE *Wisconsin Medical Journal* reprints in full the 125 recommendations (plus four minority reports) of the wide-ranging study of health care just completed by the Governor's Health Planning and Policy Task Force.

Every physician—indeed, every citizen—should become fully aware of their implications. It is a complex series of recommendations, some to the Legislature, some to the ongoing Health Policy and Program Council, some to state and voluntary agencies. Lengthy as these recommendations are, they are only a summary of the total report. The official "Final Report" is still in production—some 150 pages providing partial background for each of the recommendations reprinted here—available sometime in January at $2 per copy from the Department of Administration, One West Wilson Street, Room B-237, Madison 53702. For the complete picture, you also need the "Research and Information Supplement" (1,000 pages and an additional $5) which includes the full texts of working papers and other background documents. For example, the Supplement is the only document containing the full chiropractic report.

These proposals may have a significant impact on medical care in Wisconsin. They may in fact be a bellweather of state rather than federal action in health planning and legislation.

Your State Medical Society has supported this in-depth review of the health delivery system in Wisconsin. We will always seek to correct deficiencies, eliminate inadequacies, and improve on what we have. We must do this in some kind of partnership of government and private sector. But we cannot accept the Task Force attitude that Wisconsin health care is a monopoly in crisis, a non system on the verge of breakdown, or that any change is better than none. We believe that the laudable goals of the Task Force are best obtained through evolution of the present system which, despite some handicaps, has given our people a remarkably high level of good health. We do not believe that quality care will be made more accessible at lower cost by arbitrary centralization of pure political power over additional bureaus, commissions, and agencies. The public utility concept applied to health care may very quickly make Wisconsin a no man's land for health personnel.

The county and state medical societies of this state—through every member—will review these proposals carefully and thoughtfully. I expect we will support many of them in full or in part. Others—such as the Health Services Commission (the utility concept)— seem like "overkill" for certain health problems that beset our society, such as manpower shortages or distribution inequalities, slowly developing comprehensive planning, special health problems of the needy, undereducated and unemployed, and the need for catastrophic insurance protection.

In the next several weeks the State Medical Society, through appropriate committees, will provide analysis and proposed policy positions to the membership and the Legislature. I urge you to express your opinions to me for help in guiding our Society position. Equally important, make direct contact with your legislator. If you have any questions, please address them to me or your Society headquarters at any time.

ROBERT F. PURTELL, MD
President

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STATE OF WISCONSIN

Patrick J. Lucey, Governor

GOVERNOR'S HEALTH PLANNING AND POLICY TASK FORCE

David Carley, Chairman Ben Lawton, MD, Vice-Chairman John Gregrich, Coordinator

Governor's Health Planning and Policy Task Force Recommendations

(in chronological order of passing)

FEBRUARY 25, 1972

1. **The actual health services which are required (to overcome, ameliorate or prevent illness and health problems) for a defined population provide the proper basis for public policy and planning for health.**
   More specifically:
   - The requirements for health workers, programs and facilities are properly determined by and derived from requirements for services.
   - The entities and organizations which make up the health system must be held responsible for and accountable to defined populations. Collectively they must serve the entire population.
   - The financing of health services, insuring against the economic cost of illness, and the education of the public are service functions and are publicly accountable. They must serve everyone, and the financing and distribution of service must be equitable.
   - Policy and planning bodies, at the state, regional and local levels must be held responsible for and accountable to the populations they serve.
   - The missions of health profession education and of research are properly assigned to capable, responsible institutions as part of public policy. They are not developed by the institutions alone.
2. **The Task Force proposes the establishment of minimum standards for health insurance to regulate what benefits people receive, the language used in writing policies, and related business practices to assure citizens the most appropriate and comprehensive coverage for premium dollars paid.**
3. **The Task Force recommends the development of new state legislation defining the mandate and relationships of health planning agencies at the state and regional level.**
4. **The Task Force takes the position that priority for public funds for the mentally ill and the behaviorally disabled be redirected from support of primarily, long-term residential institutions to community based and ambulatory facilities.**
5. **The Task Force recommends that actions be taken at this time to increase the supply of physicians' services in the state.**
   - The Task Force supports the increase in physician recruitment and retention through the development and improvement of residency programs in the state. Such programs must reflect actual requirements for specific physicians' services needed in the state and will require medical school support.
   - The Task Force supports the development and improvement of continuing education programs to promote better retention of physicians by the state.
   - The Task Force supports the expansion of class size of the state's two medical schools. A class size of 160 is a reasonable goal for each.
6. **The Task Force recommends that public policy, financing and service delivery for the behaviorally, developmentally and chronically disabled must assure integration of services into a broadly defined community services system.**
7. **The Task Force recommends policy and planning for the mentally retarded and developmentally disabled be considered a matter which requires policy on the full range of necessary and appropriate services, including health.**

JUNE 2, 1972

8. **The Task Force believes that the state government has the responsibility to exercise authority to act in behalf of the maintenance of the health of all its citizens.**

   The Task Force believes that this state has the responsibility and the authority to provide means to fix accountability including but not limited to: cost control, rate review, licensure control and quality review of the components of the health delivery system.
9. **That the Task Force supports, in principle, the development of an area or regional health education plan to better develop, implement and coordinate the education of health workers.**

JULY 7, 1972

10. **The Task Force endorses legislation to repeal the prohibition in existing Wisconsin law which prevents employment of physicians on a salaried basis in hospitals and other health care institutions.**
11. **The Task Force endorses legislation to modify the state's Title XIX (Medicaid) law to permit the Department of Health and Social Services to contract with providers offering prepaid group care plans on behalf of participants in the Medicaid program.**
12. **The Task Force endorses legislation permitting treatment of venereal disease in minors without parental consent.**
13. **The Task Force endorses legislation to provide a forgiveness loan program for medical and dental students.**

OCTOBER 11, 1972

14. **The Task Force endorses the recommendation initially made by the Governor's Environmental Task Force "71" that a comprehensive environmental planning**

body be created in Wisconsin with direct ties to the executive and the legislature.

15. The Task Force recommends that health be a major consideration in determining environmental priorities and policies.

16. The Task Force recommends that an environmental health resource center be established in the University of Wisconsin System to:
    - Conduct, support and augment studies necessary for making informed environmental decisions from the standpoint of health protection;
    - Advise the executive and the legislature as well as state and local planning and programming agencies concerning environmental health questions; and
    - Provide training for professionals in the field of environmental health as well as educate the public about environmental effects on health.

17. The Task Force recommends that a committee be established by executive order to be called the school health services committee. This committee will develop legislation requiring that selected health services be provided in all Wisconsin schools.

18. The Task Force recommends that the Department of Public Instruction and the Department of Health and Social Services work with the school health services committee to develop, implement and evaluate in selected school districts a school health services pilot project. This project will be a demonstration of what can be done in the schools to improve the delivery of health services to children.

19. The Task Force recommends that a state health education policy committee be established by the health policy and program council. This committee will provide leadership at the state level for all consumer health education efforts, including school health education.

20. The Task Force recommends that areawide health education committees be established by each of the eight areawide comprehensive health planning agencies to coordinate all areawide and local programs in health education, including school health education.

21. The Task Force recommends that the insurance commissioner be empowered by legislation to establish minimum standards for health insurance to:
    - Assure a more efficient system for financing health care to provide to insureds under health insurance contracts the maximum benefits that are feasible at reasonable costs;
    - Facilitate understanding and comparison of contracts through a reasonable degree of standardization and simplification of contracts;
    - Eliminate deceptive, misleading or confusing language in contracts of insurance; and
    - Provide benefits consistent with the health care needs of the public and eliminate provisions or coverages inconsistent therewith.

22. The Task Force recommends that the Division of Family Services be directed to strengthen the fiscal management of the Medical Assistance Program by:
    - Establishing a comprehensive procedure for review of payments made under the Medical Assistance Program to assure that services paid for are actually received and are of acceptable quality;
    - Establishing more comprehensive guidelines for fiscal agents regarding cost reports, methods of payment and retroactive adjustments.

23. The Task Force recommends that the Division of Family Services be directed to establish a quality assurance committee representing health providers and users of Medicaid services to improve the standards for services rendered to Medicaid recipients.

24. The Task Force recommends that the attorney general's opinion be obtained to determine if statute 49.45 constitutes a legal barrier to prepaid health care services for Medicaid recipients. If the opinion advises that a legal barrier exists, then the statute should be modified to permit Medicaid recipients to enroll in prepaid health plans. If the opinion advises that no barrier exists, the Division of Family Services is directed to immediately provide for the enrollment of Medicaid recipients in prepaid health care plans.

25. The Task Force recommends that an effective consumer education program explaining the benefits and methods of applying for Medicaid be developed and implemented by the Division of Family Services to provide that those eligible to receive Medicaid benefits can readily determine their eligibility and obtain the preventive and medical services available in the community.

26. The Task Force recommends that the Legislative Council's Committee on Revision of Health and Social Services Laws examine present statutes on medical assistance eligibility and prepare modifications to provide that medical assistance is equitably available to the indigent population between 19 and 65 years of age.

27. The Task Force recommends that resources for the continuing education of health workers be organized to respond to regional needs. Regional continuing education committees will be formed by the University of Wisconsin Extension System in conjunction with all other health education programs in the area to identify and meet these needs.

28. The Task Force recommends that an evaluation program be established by the Health Policy and Program Council to measure the impact of continuing education programs for health workers on the health workers themselves and the public they serve. The selection of programs to be evaluated will be based upon continuing education priorities established within the areas of the state.

29. The Task Force recommends that a central information service for all continuing education programs for health workers within the state be established by the University of Wisconsin Extension System.

30. The Task Force recommends that the Wisconsin Regional Medical Program (WRMP) develop, implement, and evaluate pilot area health education systems in selected areas of the state in conjunction with appropriate state and areawide bodies.

31. The Task Force recommends that WRMP assist other areas of the state in exploring feasible development of area health education systems.

32. The Task Force recommends that statewide implementation of the area health education system concept be preceded by evaluation of the pilot programs.

33. The Task Force recommends executive endorsement of the guidelines for an acceptable health care system as a general framework for formulating health policy, for health planning and for citizen understanding of the health care system.

34. **The Task Force recommends the creation of a research and development program in Wisconsin that consists of:**

- A development and demonstration service to find and test solutions to Wisconsin's most important current health delivery problems;
- A technical assistance and outreach service to bring about rapid and rational implementation of worthwhile improvements in the delivery system;
- A research service to encourage development of new methods to identify important issues, to evaluate health delivery programs and to bring about rapid implementation of new innovations; and
- A committee of the Health Policy and Program Council to monitor and coordinate these activities.

35. **The Task Force recommends executive endorsement of the following policy guidelines for providing mental health, alcoholism, drug abuse, and developmentally disabled services:**

- That provision of a full range of services be mandatory at the county, multi-county, and regional level to assure continuity of care and to assure access to the most appropriate treatment.
- That to continue the delivery of mental health services, county mental hospitals must be incorporated into a local 51.42 plan. The local 51.42 board will then be able to purchase treatment services from a variety of appropriate service providers including the private sectors, so that the county mental hospital functions as one among several possible sources.
- That mental health clinics give top priority to developing adequate pre-care and after-care programs for severe and chronic disabilities, the psychotic, the alcoholic, the drug abuser, and the developmentally disabled.
- That local mental health systems must include alternatives to long-term, inpatient care such as day and evening outpatient and activity centered programming, halfway houses, family care facilities, emergency and outreach services and transportation where appropriate. Every effort should be made by the local 51.42 board to secure state and federal funds for these alternatives particularly through provisions in the amendments of the Social Security Act.
- That a preventive approach to mental health be adopted through special training programs for primary health care professionals and others most likely to have contact with young children and their parents. A cooperative effort between the State Division of Health and the State Division of Mental Hygiene will assure the development of appropriate curricula.
- That nonprofessionals be increasingly used in providing services.
- That extensive social rehabilitation services directed toward community living should be developed for the non-acute present population in county mental hospitals. The current staffing and treatment standards that apply to "residential care" and to "public medical institutions" should be revised to assure the provision of social treatment programs. (Specific actions could include the transfer of large numbers of current county mental hospital patients to alternate living situations. Halfway houses, intermediate facilities or like institutions may be able to house these patients but standards for services should be revised so that these clients receive adequate social rehabilitation service within the case management system. This would include revision of the standards that currently apply to "residential care" and "public medical institutions.")
- That planning for the most appropriate alternate use begin immediately at the state, regional and county levels. Primary responsibility should be placed with the county board of supervisors. Participants will include: representatives of the Health Policy and Program Council, representatives of the Department of Health and Social Services, state legislators, representatives of the appropriate public and voluntary state organizations, areawide comprehensive health planning agencies, county supervisors, county hospital trustees, county hospital personnel, other appropriate county level groups and organizations, and representatives of the citizens at large. The Health Policy and Program Council will assume leadership in integrating smaller scale planning efforts currently in process into this planning proposal.

36. **The Task Force recommends executive endorsement of the following safeguards to guarantee quality service to those currently residing in county mental hospitals who do not require acute psychiatric care.**

- The Department of Health and Social Services must take responsibility for guaranteeing appropriate support and services to those currently residing in county mental hospitals.
- In the transition period, the Department of Health and Social Services shall be vested with the responsibility of performing utilization review, program audit, and standard review for all alternatives to county hospitals, including residential care facilities and public medical institutions.
- At the local level, county and multi-county unified boards in their 51.42 plans must document working agreements between mental health facilities and other service facilities, and provide for local auditing of these programs and budgets.
- Patients receiving service through 51.42 boards should be charged for service on an ability to pay basis.

37. **The Task Force recommends executive endorsement of the following additional guidelines for the provision of alcoholism services.**

- That development of alcoholism treatment programs be given a high priority in the 51.42 plans.
- That there must be an increase in the use of nonprofessionals, especially alcoholism counsellors in local programs.
- That training in acoholism and other drug abuse be required for all health and mental health professionals. The state Bureau of Alcohol and Other Drug Abuse should provide for the development of appropriate curricula using resources available regionally and nationally.
- That flexibility in treatment programs be maintained while providing for evaluation to determine the effectiveness of programs.
- That alcoholism treatment policies and programs in industry be encouraged through classifying alcoholism as a disease which can qualify as sick leave and by requiring a publicly stated company policy on alcoholism.

38. **The Task Force recommends that legislation be enacted which will:**

- Insure that emergency ambulance service will be available to every citizen of the state within a time period appropriate to his needs;

- Charge the areawide comprehensive health planning agencies with the responsibility to develop a viable plan for the provision of emergency ambulance service in each of the state administrative districts by July 1, 1974. The plan will include:
  * Who will provide the service;
  * How it will be financed; and
  * Who will assume overall responsibility for assuring the availability of emergency ambulance service to every citizen in the area.
- Charge the state comprehensive health planning agency with responsibility for seeing that each areawide agency provides such a plan. The state will have the authority to implement an acceptable plan of services and to charge back the cost to the counties involved.
- Empower the Department of Health and Social Services to prescribe rules and regulations regarding the organization of emergency ambulance service, qualifications and training of personnel, standards for ambulance vehicles, equipment and standard operating procedures.

39. The Task Force recommends that legislation be enacted which will:

- Empower the Department of Health and Social Services to establish a system of classification of hospitals which will reflect the level of emergency medical services available at each hospital in the state and to adopt such rules and regulations as may be required to assure that the level and quality of services actually delivered are consistent with a hospital's classification.

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40. The Task Force recommends that a permanent Health Policy and Program Council be established to perform the following functions:

- Formulate and communicate health policy recommendations.
- Direct the development of the annual state comprehensive health plan, identifying Wisconsin's health needs, goals, and priorities.
- Coordinate, review and make recommendations concerning the state and areawide comprehensive health planning program, federal categorical program plans and other publicly funded health programs.

41. The Task Force recommends that the Council be continued with a new exceutive order no later than January 1, 1973, and that the executive order provide for a Council organization consistent with new responsibilities incorporated in Task Force recommendations.

42. The Task Force recommends that legislation be enacted which establishes the Health Policy and Program Council as a statutory council in accordance with chapter 15.09 of Wisconsin Statutes.

43. The Task Force recommends that the staff of the Office of Comprehensive Health Planning be the staff to the Council. Staff functions will include:

- Support of comprehensive health planning.
- Administrative support to assist and direct Council activities.
- Coordination and review of categorical programs.

44. The Task Force recommends that funding for the work of the Council be drawn from the State Comprehensive Health Planning Program, as appropriate from the federal categorical programs and when necessary from the appropriation made by S20.505 (5) (a) for state committees.

45. The Task Force recommends that membership of the Council be appointed in a manner consistent with federal comprehensive health planning legislation, stressing geographical representation and reflecting:

- Consumer, provider and government representation.
- Representation of each areawide health planning agency. And that the number of members of the Council be not more than 45.

46. The Task Force recommends that health planning legislation be enacted that:

- Identifies the scope of comprehensive health planning to include the full range of physical, mental and environmental health needs and those services, facilities and manpower required to meet those needs.
- Identifies the functions for which health planning agencies should be accountable, to include but not be limited to, evaluation and analysis of data, programs and resource allocation proposals; projection of trends; identification of alternatives; communication of findings, conclusions and recommendations to policy makers and the public; and maintenance of liaison and community organization efforts.

AT THE STATE LEVEL:

- Establishes a state office of comprehensive health planning as the sole agency to be responsible for the administration of and technical assistance to the Comprehensive Health Planning Program (recognizing and accommodating Federal Law 89–749 as amended).
- Provides for appointment of the Director of the Office of Comprehensive Health Planning by the Governor, and that other staff members be under the state merit system.
- Establishes the Health Policy and Program Council in statute with members appointed by the Governor for staggered terms to act in a policy recommending and advisory role for the Comprehensive Health Planning Agency, the Governor, and the Legislature as well as the Categorical Federal Programs requiring state plans (i.e., hospital construction, mental health centers, developmental disabilities, alcoholism, drug abuse and public health (314d).

AT THE AREAWIDE LEVEL:

- Establishes a single areawide comprehensive health planning agency to be responsible for the administration of the comprehensive health planning responsibilities within each of the state's uniform administrative districts (recognizing and accommodating Federal Law 89–749 as amended).
- Assures that areawide comprehensive health planning agencies be representative of and accountable to the populations they serve.
- Assures that areawide agencies provide the State Agency and Health Planning Council with a 5-year planning document to be updated annually.
- Provides that planning be based on needs and resource assessments for both:
  * Areas of physical, environmental and mental health.
  * Categorical Federal Programs (in cooperation with the appropriate state and local categorical boards and agencies).
- Provides for state grants-in-aid to areawide comprehensive health planning agencies in order that they can fulfill their mandate.

- Provides that each areawide agency will be represented on the Council.

ESTABLISHES A STATE GOAL OF:

- A fully developed state and areawide comprehensive health planning capability by 1975 with uniform minimum comprehensive health planning capability in each administrative district of the state. (The Task Force emphasized the importance of preventing duplication of staffs doing comprehensive health planning at the state and areawide levels.)

47. The Task Force recommends that the extraordinary high cost associated with highly specialized categorical care be accepted as a public responsibility to be shared by all rather than to be paid by the few victims.

48. The Task Force recommends the establishment of publicly funded support for comprehensive non-categorical protection from all exceptional health care costs as preferable to the proliferation of separate categorical programs.

49. The Task Force recommends that the Health Policy and Program Council be given the responsibility to evaluate all proposals for public funding of categorical health care programs, to recommend to state government the appropriate priority for proposed and existing programs relative to other health care programs and issues, and to call for and receive evaluation of such programs established under public funding, whether state or federal.

50. The Task Force recommends that legislation be enacted which directs the commissioner of insurance to establish an accident and health insurance plan for persons unable to regularly obtain such insurance by amending 619.01 of the state statutes (mandatory risk-sharing plans) to require all insurers writing accident and sickness insurance in Wisconsin to participate in such a plan.

51. The Task Force recommends that insurance premiums under this system be state subsidized on a sliding scale, conditioned by family income and size, for those persons who are not eligible for public assistance.

52. The Task Force recommends that the state participate in a percentage of the underwriting losses in providing such insurance, not to exceed 75 percent.

53. The Task Force recommends a unified approach to the delivery of services for mental illness, alcoholism, other drug abuse and developmental disabilities by amending section 51.42 of the Wisconsin Statutes to provide for the following:

- That the legislation be made mandatory.
- That citizen involvement be required in the planning and development of 51.42 comprehensive community services for the mentally and developmentally handicapped as well as in the review by Areawide Comprehensive Health Planning agencies and by State Health Policy and Program Council.
- That checks and balances be incorporated in the legislation to insure participation of citizens including consumers of specific services and providers including local program administrators representing the major disability groups. Such representation is to be included in planning, program review and appeal at the local, district and state level.
- That under the unified community services boards, county hospitals and clinics and other mental health facilities merge for administrative and reporting purposes.

54. The Task Force recommends that legislation be enacted which directs the Department of Health and Social Services to administer the following funding changes to guarantee equitable access to a full range of services to all citizens:

- Program budgeting should be used for both the county hospital and mental health clinic systems. Funding should be organized along the present clinic grant-in-aid procedures, rather than the current method of funding county hospitals which frustrates fiscal planning and fails to insure fiscal accountability.
- That state subsidy for a full range of outpatient services under the unified community services board be set at 90% of actual operation cost.
- If full funding is not possible, consideration should be given for a sliding scale formula with a base no lower than 75%.
- That state subsidy of purchased public and private inpatient care in unified community services plans should be set at the 90% level for the first 30 days of inpatient treatment, 75% for the next 60 days, 50% for the next 90 days, 25% for the rest of the year and 0 for more than one year. At the end of one year, there should be an independent review of the patient to determine the need for continued inpatient psychiatric care. If so, the county may refer the patient to one of the mental health institutes at the 50% rate (the current rate) or the county may continue unified community services board level funding, at a 50% level, by placing the individual in an appropriate community facility.
- Until acute treatment services are phased out of the state mental hospitals, there should be a 90% charge-back to the counties for county residents admitted for acute treatment beginning July 1, 1974.

55. The Task Force recommends that the insurance commissioner be charged to promote the following changes in the minimum standards for private insurance benefits for the behaviorally, developmentally and chronically disabled:

- Extension of coverage to a range of outpatient care for mental illness, alcoholism and other drug abuse such as partial hospitalization, day care, rehabilitation, half-way houses and other alternatives to 24-hour care, with no exclusions for services in public facilities. Under the present system, patients with insurance are financially excluded from high quality public programs.
- Extension of coverage for services by a range of personnel, in addition to psychiatrists, working in a variety of settings. These personnel would include such personnel as psychologists, social workers, alcoholism and drug abuse counsellors as well as allied health personnel.
- Extension of coverage of services to alcoholism on an outpatient and inpatient basis to all group and individually held policies.

56. The Task Force recommends that the Department of Health and Social Services adopt the following service guidelines:

- That acute detoxification services for alcoholics should occur in community general hospitals or other health facilities and should be readily available in every area to Wisconsin's population. All of these acute detoxification units should be linked

to additional treatment services through the unified community services plan.

- That the titles and functions of the state mental hospitals be changed to become "mental health institutes".
  - * Their functions should be redesigned to be the provision of tertiary care, specialized case consultation, research and training.
  - —More specifically, this provision of tertiary care will include services which are highly technical, usually very expensive and must be regionalized to conserve money, specialized equipment or highly specialized teams of health workers. The Task Force estimates that 150–200 beds will be required at each institute to perform this function.
  - —The institutes will offer their resources for the training of mental health professionals, although this training will not necessarily be conducted on the premises, but will be decentralized.
  - —The mental health institutes will phase out the provision of basic acute treatment services by July 1, 1975, including to children and adolescents.
  - —There shall be a charge-back of 90% to the counties for patients admitted to the mental health institutes for acute treatment services, beginning July 1, 1974.
  - —At the end of six months of continuous inpatient treatment within the county unified program, refractory patients should be evaluated and the state institute staff brought in to aid in the treatment. At the end of one year, patients still requiring intensive psychiatric programming will be reevaluated at six month intervals, reimbursed at 50% cost of care if retained in intermediate care programs at the community level and reimbursed at 50% cost of care at the specialized tertiary care rate in the mental health institutes if the institute staff feels that the individual should receive this specialized care for primary and secondary care.
  - * To perform these functions with fewer patients and beds, the institutes will require a lower operating budget and fewer treatment staff. Future staffing will then include State Division of Mental Hygiene program consultant staff decentralized to the institute and district level. District Division of Mental Hygiene program consultant staff and the staffs of the mental health institutes should be organized into an effective, interrelated structure.
- Central state hospital will be closed. Patients requiring inpatient treatment should be transferred to the two "mental health institutes" or otherwise accommodated.

57. The Task Force recommends that legislation be enacted to make the "critical health problems curriculum" mandatory.

- Development, implementation and monitoring is to be done jointly by the Department of Public Instruction and the Health Policy and Program Council.

58. The Task Force recommends that legislation be enacted that ensures that alcoholism be treated as a health problem by removing public drunkenness from the state statutes and local ordinances as a criminal offense and by providing means for entry into the health system for those in need of treatment services.

59. The Task Force recommends that the review and development of new standards for non-psychiatric medical and nursing care in Wisconsin county mental hospitals be undertaken by appropriate sections of the State Medical Society and the Wisconsin Nursing Association in conjunction with other health professionals and allied personnel. These sections will report their recommendations to the Health Policy and Program Council by February 1 to be published as new rules by July 1, 1973.

60. The Task Force recommends that the Department of Health and Social Services alter state funded programs for the elderly, particularly the state Medicaid program, to place emphasis on preventive services and noninstitutional care.

61. The Task Force recommends that the Health Policy and Program Council along with the Division on Aging take the leadership in working with the appropriate agencies to promote these changes:

- That minimum standards for private insurance be established to place emphasis on the preventive aspects of medical care.
- That public funds be sought at the federal or state level to support and strengthen existing services for those who wish to remain in their own homes or in their own communities.
- That public funds be sought at the federal or state level to encourage innovative or experimental programs to keep older people active and to prevent needless institutionalization.
- That training programs for health care personnel in dealing with the elderly and research into the health problems of the elderly be developed.

62. The Task Force recommends that the development of child-adolescent mental health services be given high priority in the comprehensive mental health programs established under the unified community services (51.42) boards.

- The areawide health planning agencies should include the development of regional plans for child-adolescent mental health services in their next years programs and assist 51.42 boards in their efforts.

63. The Task Force recommends that, to provide solid planning data and to assign appropriate responsibility for state supported services, the Health Policy and Program Council, with assistance from appropriate state departments and divisions, should review, coordinate and complete where necessary current efforts to study the status of state funded mental health services for children and adolescents, their type and duration and should recommend appropriate modifications in programs, funding and organization of such services.

- This review should include the applicable programs in the Department of Public Instruction and the Divisions of Health, Family Services, Mental Hygiene and Corrections in the Department of Health and Social Services.

64. The Task Force recommends that funding priority for child and adolescent services should be for community based secondary care services, which include short-term shelter care, and the use of community general hospital pediatric and psychiatric wards as resources for crisis intervention, when indicated.

65. The Task Force recommends that acute inpatient treatment for children and adolescents be phased out of the state mental hospitals by July 1, 1975. Highly specialized tertiary care services are appropriate func-

tions of the proposed mental health institutes, which will replace the present state mental hospital programs.

66. The Task Force recommends that funds be made available for state funded demonstration and research projects with priority given to proposals which:

- Involve an integration of existing programs into community systems to meet the spectrum of mental health needs of children.
- Involve collaborative efforts of mental health workers, other health and social services professionals and educators to more clearly define specific needs of children, the most appropriate way to meet those needs and the methods most appropriate for evaluating the effectiveness of services provided.

67. The Task Force recommends that interdisciplinary consultant teams, with the combined capabilities of the current children's consultation service and the development evaluation centers, be available on a regional basis and supported with state funds.

68. The Task Force recommends the following guidelines for use in local communities, counties and multi-county regions for the development of plans for child-adolescent mental health services:

- Mental health services should be available to all children who need them.
- Local and regional plans for providing mental health services to children and adolescents should reflect the special needs, resources and priorities of that area.
- The organization of services to children and adolescents should assure continuity of care.
- Services should be provided as close to a young person's home as feasible, because of the importance of involving parents and other members of the community.
- A child-adolescent mental health program should offer a continuum of services coordinated with and/or cooperating with other child and family health and social service agencies.

69. The Task Force endorses the inclusion of developmental disabilities services in the comprehensive programs of the unified 51.42 community services boards.

70. The Task Force recommends that adequate standards, representation, monies, program review and evaluation procedures, policy guidelines and consumer participation in planning for services to the developmentally disabled be assured through the system of checks and balances recommended for mental health and alcoholism services.

71. The Task Force recommends that the Health Policy and Program Council have a permanent developmental disabilities committee.

72. The Task Force recommends that the state fund services to the developmentally disabled through a grant-in-aid formula and utilize program budgeting to highlight the commitment of the state and of local communities to services for the developmentally disabled.

73. The Task Force recommends that particular emphasis be given to the following unmet needs of the developmentally disabled:

- There should be a reduction in the size of the colonies and a greater support for group homes where appropriate.
- There should be an increase in the availability of respite (short term) care. There should also be an assumption by the state of a shared responsibility with the parent or guardian of a developmentally disabled child living in his own home for his life long care. This responsibility for adequate care and support should be assumed by the state after the parent or guardian is no longer able to provide it.
- There should be an expansion of these services: genetic counseling, community living for adults, legal protective services and procedures for assuring accountability of educational services.
- There should be further efforts to educate the general public about the nature of and capabilities of the epileptic.

74. The Task Force recommends that the Health Policy and Program Council take the leadership in assuring that Substitute Amendment 2 to Senate Bill 51 be revised in line with these suggested guidelines:

★ *Admissions:*

- Every feasible effort at voluntary services or crisis intervention should be made prior to a mental hearing in court.
- Prior to a hearing in court, inpartial screening of a petition for such mental hearing should be carried out by private or public mental health or social service professionals appointed by the court. Persons should not be involuntarily admitted to state hospitals during the present intermediate phase of conversion from basic acute psychiatric care at state hospitals to care at local facilities unless they have been screened by the local mental health facility.
- Mental examiners at court hearings for involuntary admission should be either psychiatrists or licensed clinical psychologists. The non-psychiatric physician is not qualified to so serve. Likewise, informal admissions as defined in Substitute 2 of Senate Bill 51 of 1971, should be amended to allow the use of various licensed mental health personnel as ratifiers of the admission. Such ratifiers should not be restricted to psychiatrists or physicians.
- Emergency detention procedures for the mentally ill, alcoholic, and chronic drug abusers should be continued, but with restrictions on such procedures. Detentions in health facilities by police should be authorized by the superintendents or designated agents of those health facilities.
- Emergency detentions of the mentally ill, alcoholic, and chronic drug abusers should be limited to 48 hours.
- Emergency detentions of the mentally ill, alcoholic and chronic drug abusers should be permitted the use of private facilities if such are available locally, if the private facility agrees to such detention and if the detainer assumes financial responsibility for such detention.
- Emergency detention and treatment of alcoholics and drug dependent persons should only take place in a health facility.
- The alcoholic must be permitted to enter public hospitals on a voluntary basis. The whole present process of involuntary admission as sole access to the mental health delivery system is indefensible, the present system is dehumanizing to the alcoholic involved.

★ *Legal Services:*

- Involuntary admission and judicial orders for periods of observation for the mentally ill, alcoholic and chronic drug abusers need addi-

tional safeguards for the civil rights of the accused. Among these are:

* Right to prior notice of mental hearings.
* Mandatory right to counsel.
* Right of prior notification of legal rights by professional health staff or legal authorities.
* Right to usual due process mechanisms:
  —Open courtroom unless waived.
  —Notifications as to names of petitioners.
  —Right to cross-examine petitioners and examiners under oath.
  —Court and detention facility or hospital records should be open.
  —The assumption of competency until proven otherwise.
  —The opportunity to offer contrary evidence and witnesses for the accused.
  —The mandatory right of jury trial unless waived by the accused or his attorney.
* Further elaborations on due process on involuntary admissions, involve the right of friends, family, ministers and private physicians to be present during examinations.

- The right of appeal to the next level of judicial appeal for adjudication of mental illness, alcoholism or chronic drug abuse should be firmly established.
- Each mental hygiene authority should establish for its jurisdiction a "mental health ombudsman" to whom informal appeal is possible. Such a person should act as the advocate for detained or involuntarily admitted persons.
- The mentally ill, alcoholic and chronic drug abusers who are detained on an emergency basis are entitled to certain safeguards protecting their civil liberties:
  * Notification of legal rights to counsel and representation.
  * Immediate notification of the family and at least two friends.
  * The right to complete two telephone calls at the expense of the detaining facility.
- Review process for monitoring the progress of involuntarily admitted persons should be sharply enumerated and defined. The California Short–Doyle Act is one excellent model for such safeguards.
- Denial of patients' rights should be adequately guarded. Substitute 2 to Senate Bill 51 contains many such safeguards, but the denial of such rights should be routinely forwarded to the involuntarily admitted person's attorney and to the court of record on a monthly basis.

★ *Services:*

- Staffing of detention and treatment health facilities for the mentally ill, alcoholic and chronic drug abusers must be adequate.
- Detained or involuntarily admitted persons may be involuntarily treated. Electro-convulsive therapy or lobotomy may not be involuntarily imposed. Drugs administered involuntarily to detained or involuntarily admitted persons should be recorded as such and made available to the court of record and the patient's attorney.
- All workers in public mental health facilities should be guaranteed, by statute, the right to testimonial confidentiality.

75. The Task Force endorses the licensing and accrediting of facilities for the treatment of drug abuse. The Health Services Commission should develop appropriate criteria and procedures in consultation with the Department of Health and Social Services and the area health planning agencies. Immediate steps should be taken to insure that hospital based drug detoxification be available in every area. All of these acute detoxification units should be linked to additional treatment services throughout the local unified communuity services plan.

76. The Task Force recommends that public refunding of current programs and funding of proposed drug information and education programs be authorized only after evaluation of the program staffing and content. The criteria for such evaluation should be developed by the Bureau of Alcohol and Other Drug Abuse prior to July 1, 1973.

77. The Task Force recommends that the drug education portion of the "critical health problem" program of the Department of Public Instruction in the public schools should be ongoing and integrated within the general curriculum. The why's of drug abuse and a focus on people and problems of living should be stressed.

78. The Task Force recommends that the Health Policy and Program Council study with the Dangerous Substances Control Council the health and policy implications of present legislation controlling the use and possession of illegal drugs.

79. The Task Force recommends that the State Medical Society, the State Pharmaceutical Association and other professional associations take the leadership in creating the means to restrict the improper prescription and use of mood-altering drugs.

80. The Task Force endorses legislation permitting treatment of drug abuse in minors without parental consent.

81. The Task Force recommends that the Bureau of alcohol and other drug abuse and the local unified community services boards adopt the following guidelines for treatment services for drug abuse:

- Local police and health facilities should integrate their efforts in the area of drug abuse and emphasize a social–rehabilitative approach.
- Drug abuse treatment programs should incorporate attention to many factors contributing to drug abuse and include many professional and paraprofessional disciplines.
- Drug abuse programs should be community based, health oriented and should make use of paraprofessional ex-drug abusers.
- Long-term hospitalization should be avoided.

82. The Task Force recommends that the Department of Health and Social Services seek funding from disabled aid, Title 4A of the Social Security Act and from other usual sources of aid for those disabled by drug dependency.

83. The Task Force recommends:

The Department of Health and Social Services should establish a health data center to:

- Coordinate and consolidate existing health data functions within the Department.
- Provide technical assistance to agencies requesting services to meet the specific needs required for decision-making at the local or areawide level.

- Assist areawide and local staff to expedite information collection, retrieval and dissemination.

The Health Policy and Program Council should provide for Wisconsin participation in the federal–state–local health statistics system authorized in P.L. 91–515.

The Council be assigned the responsibility and authority to assure timely response to Council data needs. Fiscal and program data should be gathered in such a way that they can be integrated for analyses applied to specific program planning issues and administrative decisions.

84. **Be it resolved that Task Force recommendations which address health care and health care services be considered to include dentistry as a health care service essential to the maintenance of good health.**

85. **The Task Force recommends that a certificate of need bill as accepted by the Task Force on October 23, 1972, be enacted.**

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86. **The Task Force recommends the establishment by legislation of a free-standing, state-level health services commission to:**
    - Be composed of three full-time commissioners appointed for staggered terms of six years.
    - Have a staff sufficient to carry out its duties.
    - Be subject to the provisions of Chapter 227 of Wisconsin Statutes (Administrative Procedure and Review) which includes requirements for public disclosure and appeal.

87. **The Task Force recommends that the State Health Services Commission have authority to:**
    - Develop and implement a system for review and approval, disapproval or modification, of the rates of heatlh care institutions, such as, but not limited to: hospitals, nursing homes, county homes, and home health care agencies.
    - In conjunction therewith, the Commission shall compile, evaluate and comment on other factors of health care costs.
    - The Commission may contract with any competent organization to effect the purposes of this section but it may not delegate its responsibility.
    - Develop and implement a licensing system and grant licenses to health care institutions, such as, but not limited to: hospitals, nursing homes, county homes, and home health care agencies. This licensing system shall exclude private physicians' offices. Under this system each license issued shall designate as a condition of licensure, those minimal services which must be provided by each institution to the population it serves. The Health Services Commission may delegate to other organizations the data collection and inspection functions relating to licensure.
    - Develop and administer a Certificate of Need Program in collaboration with areawide health planning agencies and the state office of comprehensive health planning as incorporated in the amended Certificate of Need legislation recommended by the Task Force on October 23, 1972.
    - Monitor and evaluate a health care quality assurance program and charter appropriate organizations to facilitate the implementation of such a program.

88. **The Task Force recommends that a publicly chartered but nongovernmental body or bodies be created to provide support and supervision at the state level for continued development and strengthening of an excellent system of peer and professional health service quality maintenance review.**

89. **The Task Force recommends that the chartered organizations be charged with developing a variety of reasonable and effective means for evaluating the continuing technical knowledge and practical competence of health care professionals and health care institutions.**

90. **The Task Force recommends that the chartering agency, empowered to set the standards and conditions of chartering, be the State Health Services Commission.**

91. **The Task Force recognizes the need for immunity provisions in this legislation for people participating in quality review processes.**

92. **Data collected and conclusions reached under the quality assurance and review system shall be treated as privileged information. This provision does not preclude presentation of summary information without identification of persons for public education purposes.**

93. **The Task Force recommends that this legislation include three nine member program councils on rate review, licensing, and quality assurance to advise the commission of rule making and administration in each of the three program areas.**

94. **The Task Force recommends that a health manpower committee be established as part of the Health Policy and Program Council to advise the council on matters relating to the education of health professions and health manpower.**

95. **The Task Force recommends that the health manpower committee be charged with receiving and making recommendations in accordance with the health manpower and cost information developed by the Task Force.**

96. **The Task Force recommends that the committee be composed of:**
    - Five members from public educational institutions.
    - Three members from private educational institutions and provider groups.
    - Representatives from each health education consortium (Area Health Education System.)
    - A representative of the Health Policy and Program Council.

97. **The Task Force recommends that the committee be supported by staff from the Health Policy and Program Council.**

98. **The Task Force recommends that legislation be enacted to create a legislative joint survey committee for licensing and certification to simultaneously examine the interrelated issues of licensing and certification of health professionals and to review any legislation which calls for a change or addition to present licensing laws for health professions.**

99. **The Task Force recommends that the state executive declare a moratorium on new licensing and certification of health professions pending the creation of a legislative joint survey committee for licensing and certification and the examination and recommendations of the state health profession licensing system by the joint committee.**

100. **The Task Force recommends that the present professional practice acts be amended to permit the delegation of responsibility to individuals properly trained to perform health service functions.**

101. The Task Force recommends that the Health Policy and Program Council review the concept of institutional licensure and recommend necessary administrative or legislative actions to allow for a limited institutional licensure demonstration project within the state.

102. The Task Force recommends that the health manpower committee of the Health Policy and Program Council be charged with convening a joint practice committee of the Wisconsin Medical Society, the Wisconsin Dental Society, the two nursing societies and other professional associations to examine and make recommendations regarding the interrelationships of the various occupations.

103. The Task Force recommends that legislation be enacted to require the addition of one lay member and one member of a health profession other than the one being licensed to the licensing board of each health profession.

104. The Task Force recommends that the administrative codes of the health licensing boards be modified such that in order to receive a license renewal, health workers who do not practice their profession for one year or more be required to show evidence of competency to their respective licensing boards. Such evidence shall consist of certification by an institution or employer of a satisfactory level of competence in such form as determined by the respective licensing board.

105. The Task Force recommends that the committee on health manpower of the Health Policy and Program Council in liaison with the advisory committee to the State Board of Nursing be charged to develop an annually updated plan for nursing and nursing education. Such planning shall be done in conjunction with the state areawide comprehensive health planning agencies and the area health education systems as they develop. Planning should include policy recommendations regarding the proposed development of new programs or the expansion in scope or enrollment of existing programs.

106. The Task Force recommends that the nursing education plan include the development of a totally integrated system in post high school general education. This system of nursing education should provide freedom for upward mobility. Each school should be required to provide articulation with other levels of nursing education. Collaborative efforts of schools of medicine, dentistry, nursing and allied health should provide multi-disciplinary programs to insure that students are prepared to participate effectively as members of health service delivery teams.

107. The Task Force recommends that the proposed legislative joint survey committee on licensing and accreditation study the nursing practice act, modify it to reflect the changing practices in nursing and nursing education.

108. The Task Force recommends the expansion and development of masters degree programs in nursing for preparation of nursing faculty, nursing administration and clinical nurse specialists.

109. The Task Force recommends that provision be made for doctoral studies for nurses in Wisconsin.

110. The Task Force recommends that the nursing committee of the Wisconsin Regional Medical Program and other nurse researchers be designated to act in liaison with the recommended research and development committee of the Health Policy and Program Council to assure that: research and demonstration projects which are developed concerning nursing are coordinated with projects in other health disciplines, and that information from the projects is disseminated for use throughout the state.

111. The Task Force recommends that nursing programs throughout the state work in conjunction with the University of Wisconsin Extension and other educational agencies to promote regionalized continuing education for nurses who are not in active practices as well as those who are.

112. The Task Force recommends that state funds be allocated for legislative forgiveness loans for nurses. Such loans should be used as an incentive to attract nurses into areas of need. This program should be established for a definite period, preferably ten years, and be reevaluated for continuation after eight years.

113. The Task Force recommends that the health sciences center of the University of Wisconsin examine the merits of training a new type of mental health professional including a proposed doctor of psychological medicine.

114. The Task Force endorses the proposal by the Department of Health and Social Services to create a state grant-in-aid program to support the development of local multi-county, single county and city/county public health agencies charged with delivering needed public health services and with facilitating citizen access to existing services by providing a central source of information and referral.

115. The Task Force recommends that health and health related programs administered or funded by the state that do not conform to the boundaries of the uniform administrative districts be reassessed and that steps be taken to bring them into conformance with the districts.

116. The Task Force recommends that an areawide administrator of the Department of Health and Social Services be placed in charge of all programs and personnel of the Department of Health and Social Services in each of the eight state administrative districts.

117. The Task Force recommends that the state of Wisconsin accept the affirmative responsibility of providing its citizens with the information necessary to make intelligent decisions with respect to use of the chiropractic by directing the education committee of the Health Policy and Program Council to devise and implement programs to educate all citizens regarding the nature of chiropractic theory, its lack of scientific validity and the potential hazards associated with its use.

Implicit in this proposal is the recommendation that the Task Force oppose any legislation which requires that coverage for chiropractic services be included in any form of insurance policy.

118. The Task Force recommends that the state refuse to permit the use of any public resources for any purpose which would tend to further the use of chiropractic.

Implicit in this proposal is the recommendation that legislation be enacted to remove chiropractic services from coverage by the Workmen's Compensation Law.

119. The Task Force recommends that no change be made in the existing statutory requirements for the licensure of chiropractors. That the Basic Sciences Examining Board be directed to re-examine regularly the standards for successful completion of the basic sciences examinations in those states with which applicants seek reciprocity pursuant to sec. 445.07, Wisconsin Statute.

120. The Task Force recommends that legislation be enacted to:

- Provide that the Administrator of the Division of Health appoint an advisory committee on tuberculosis to advise him in developing policy and setting standards for quality of care, methods of prevention, diagnosis, in-patient and out-patient treatment, evaluation of cases, and surveillance of facilities.
- Repeal the applicable section of the existing "free care" statutes which provide for state subsidies for in-patient care in tuberculosis sanatoria. Such repeal shall not take effect until the plan in the above paragraph is in effect.
- Require that all insurance companies selling insurance to residents of Wisconsin not exclude coverage for the in-patient treatment of TB by an approved facility or an approved out-patient service as approved by the Division of Health of the Department of Health and Social Services.
- Specify that in order for a facility to be certified for acute in-patient care it must meet the rules and regulations of the department that are applicable to general hospitals (H24).
- Permit that portion of the existing "free care" statutes to be continued which provides for subsidy by the state for out-patient care of TB cases, by an out-patient service, which meets the aforementioned standards.

121. The Task Force recommends that:

- A network of out-patient resources be promoted by the department in accord with these standards for the treatment of TB to assure that each district of the state has adequate resources to serve its population.

122. The Task Force recommends that the state's group insurance board be directed to revise its policies relative to health insurance in the following manner:

- Pay a specified dollar amount per month toward health insurance for each employee and consider the use of payment incentives to providers to encourage improvement in the quality and comprehensiveness of health care.
- Review for approval several health care plans that offer various methods of delivering and paying for health care including alternatives to fee-for-service such as prepaid capitation and prepaid group practices.
- Provide subscribers an opportunity to choose from among approved health plans available in their area, and to provide annually at a specified time the opportunity for all subscribers to keep their plans or to select a different plan from among the approved plans.
- Give preference to plans which are also offered to other individuals and groups in the state at costs not to exceed the premium rate of the plan offered to the state.

123. The Task Force recommends that the group insurance board consider the following factors in assessing plans to be endorsed:

- The plan should include preventive and maintenance services, full outpatient benefits, home health care benefits, and in and out of hospital mental health and alcoholism services not to exclude payment for services in public facilities.
- The estimated out-of-pocket expense to subscribers should be predictable and minimal.

In considering prepaid plans for endorsement both group and non-group (closed or open panel), the Board must be assured that:

- There are safeguards against under-utilization of the plan.
- The plan provides a full range of appropriate specialists in addition to primary care practitioners.
- The participating physicians are geographically located to be easily accessible to enrollees.
- Patient education programs are available to enrollees.
- Unified patient record system is maintained.

124. The Task Force recommends that the group insurance board during the first two years of a multi-choice health care program provide for the continuing evaluation of the approved plans and modify its criteria for approval of plans based on the results of such evaluation.

- In order to facilitate evaluation, the Board should insist on uniform accounting procedures for all approved plans and develop methods for determining out-of-pocket expense to subscribers in all approved plans.

125. The Task Force endorses the proposal by the Wisconsin Pharmaceutical Association that a drug quality review board consisting of physicians, pharmacists and others prepare a formulary of prescription drug products deemed clinically effective and chemically equivalent ranked in order of wholesale cost from which the pharmacist will dispense the available prescription drug product with the lowest wholesale cost, unless the prescriber specifically withholds such authority from the pharmacist.

70-YEAR-OLD DOCTORS GET BREAK IN DUES

The State Medical Society of Wisconsin reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues-exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classification can be arranged.

Task Force Minority Reports

Dissenting Opinion on the Health Services Commission

by Earl R. Thayer

Concurred in by George Handy, MD and Barbara R. Shade

These comments are submitted under the title "minority report" because this is the only avenue open to a Task Force member who wants the readers of this report to know there are other more acceptable and effective alternatives to public accountability than those adopted by this Task Force as recommendations for regulating the health care system. These minority comments apply only to the Health Services Commission aspects of the Task Force report on regulation.

Your attention is directed to the statement we approved on page one of the section titled "Delivering Health Services": "At the heart of the Task Force work was a study of the delivery of health care services to the people of Wisconsin." We very properly declare that health care is people helping other people . . . that health care is provided by health workers, not by a "system" . . . that action on our recommendations affects not only an impersonal "system" but also the people who work within the system and the people they serve.

Thus the effectiveness of proposed regulation as a means of public accountability will be determined not so much by its application to the "system" as by its application to people—health workers and those they serve. In other words, we must beware of improving the "system" while at the same time adversely affecting health workers and the public.

The Task Force has recommended that a three-man Health Services Commission be the means by which the state achieve regulation of health care. I believe this is the least desirable of several approaches to public accountability of providers and facilities. It is a monolithic, centralized approach to the solution of people problems. It concentrates greater and greater power in the hands of fewer and fewer. The Commission adds another and unnecessary layer of bureaucracy to a system which the Task Force has declared is already too large, too high cost and too insensitive.

First, a Health Services Commission is not required nor is it desirable for an effective certificate of need program. Certification of need is acknowledged to be a planning process. It is fully capable of being effectively administered by the areawide ("B") and statewide ("A") comprehensive health planning agencies. Why add another bureau with more cost, more time consuming red tape, more roadblocks to health care delivery? Using a Health Services Commission for this process is placing emphasis on the system instead of on people. Further, the certificate of need proposal as presently worded would involve virtually every physician's office. There is no documentation, no evidence of any kind that health care will be improved or made more reasonable if physicians are subjected to the lengthy, costly and uncertain process of certificate of need, nor has any of the other sixteen states with this legislation demonstrated the need for inclusion of physicians' offices. They should in fact be excluded. Wisconsin is already medically underpopulated. Across-the-board regulation as contemplated by the Health Services Commission will aggravate the problem by discouraging physicians from coming to Wisconsin and motivating others to leave.

Second, the Health Services Commission is unnecessary as an instrument of institutional licensing. This function is currently performed by the Division of Health. If there are shortcomings, they are those of manpower and finances, not lack of authority or proper direction. We should build on the strength of an existing program already well administered rather than create an entirely new system. In this matter of institutional licensing the Task Force has wisely excluded private physicians' offices since the M.D. is already licensed and publicly accountable to a board appointed by the Governor with the approval of the Senate.

Third, a Health Services Commission is totally unnecessary to the effective and adequate functioning of a quality assurance program. A statewide body known as Wisconsin Health Care Review, Inc. (WHCRI) has been created by the medical, hospital and dental professions. It will shortly be expanded to include all providers. Its directing board includes eight providers, with invitations currently extended to four consumers. It is already coordinating local peer review units in the performance of quality review functions for Medicare, Medicaid, private insurance carriers and the general public. WHCRI employs principally educational and professional means to assure appropriate quality, utilization and cost of health care services. When necessary these same devices are a strong sanction for public accountability. When coupled with the stringent economic sanctions already associated with governmental financing programs such as Medicare and Medicaid, WHCRI would appear to have all the means and authority required for an effective system of quality control.

Fourth, a Health Services Commission is unnecessary to institutional rate review already under way in Wisconsin through a joint Blue Cross and Wisconsin Hospital Association program involving representation from providers, consumers and government. Its effect will almost certainly be statewide. A Commission adds only duplicative regulation to a sound program of public accountability.

In summary, each of the programs proposed by the Task Force as a responsibility of the Health Services Commission is already under way either through government or a combination of private sector-government cooperation. It is doubtful that an overriding regulatory agency of the public utility type will increase their effectiveness in publicly accounting for the care and services rendered to people by providers and institutions. Such an addition to the system will almost certainly aggravate health manpower shortages and thus adversely affect the citizens we seek to serve. The most that is needed is support for and strengthening of existing mechanisms within their present structures, with coordination through the Health Policy and Program Council.

Memorandum of Reservation on the Health Policy and Program Council

by John Martin

Concurred in by Susan Kay Phillips

Task Force recommendations:

The Task Force recommends that a permanent Health Policy and Program Council be established to perform the following functions:

- **Formulate and communicate health policy recommendations.**
- **Direct the development of the annual state comprehensive health plan, identifying Wisconsin's health needs, goals and priorities.**
- **Coordinate, review and make recommendations concerning the state and areawide comprehensive health planning program, federal categorical program plans and other publicly funded health programs.**

The Task Force further recommends that the Council be continued with a new executive order no later than January 1, 1973, and that the executive order provide for a Council Organization consistent with new responsibilities incorporated in Task Force recommendations.

The Task Force further recommends that legislation be enacted which establishes the Health Policy and Program Council as a statutory council in accordance with Chapter 15.09 of (The) Wisconsin Statutes.

The creation, in 1971, of the Governor's Health Policy and Program Council reflected a concern shared by many individuals over health care in Wisconsin. Certainly something needed to be done to bring a sense of direction to health planning and the policy-making process.

A majority of Task Force members view the Health Policy and Program Council as *the* viable mechanism for resolving most, if not all, problems associated with health planning and policy-making. I do not share that view.

When one carefully reviews the many recommendations adopted by the Task Force, one is impressed by the frequency with which primary responsibility for planning, directing, coordinating and even controlling health care activities is assigned to the Health Policy and Program Council. Its powers and responsibilities would, to say the least, be impressive.

Unfortunately, the Task Force has not adopted useful recommendations, to the Governor or the Wisconsin Legislature, concerning the organization, powers and administrative processes which will permit the Health Policy and Program Council to accomplish its complex assigned mission. How is the Council to be structured? Under what conditions will its members be appointed and served? What will be its relationship to other public agencies and private interests serving the health needs of Wisconsin's citizens? What practical means will be at its disposal to enforce the policies and plans it will adopt, especially those affecting other state agencies, regional bodies, local agencies, both public and private?

Had even these questions been answered by the Task Force, there is an issue of paramount concern that consciously or unconsciously has not been adequately dealt with: the Council's accountability to consumers and providers of health care in Wisconsin. Stated in another way, how do consumers and providers, as partners in the delivery of health care services, hold the Council accountable should it fail to exercise its vast responsibilities and powers effectively and judiciously? Is it really reasonable for the citizens of this state to expect what would probably be a large, broadly-based body of appointees, serving on a part-time basis, to accomplish what the vast state–regional–local bureaucracy has not been able to accomplish? And if it fails, in whole or in part, what sanctions are to be imposed upon the Council and by whom?

It is incumbent upon the Task Force to support its proposal for creation of the Health Policy and Program Council with specific recommendations concerning council organization, powers and administrative processes. In addition, these recommendations should be supported with clear evidence that such a council represents the best alternative open to the state in bringing direction to health planning and policy-making.

Dissenting Opinion on Number Ten of Task Force Guidelines for an Acceptable Health Care System

by Dennis J. Purtell

Concurred in by John Hirschboeck, MD, Leonard W. Hickey, and Barbara Brown, RN, EdD

The underlying premise which cannot help but be read into Guideline No. 10 is that abortion on demand, euthanasia on demand, or any other items which may be "socially or morally controversial" should be made available to those who desire them, no matter how distinct a minority they may be, simply because they are "health related." The question of abortion on demand is too complex an issue to be glossed over with such a generality, which can only be read by those wishing to adopt that proposition as being clearly and totally in support of their position.

Statement of Concern By Task Force Members Relative to Number Ten of Task Force Guidelines For an Acceptable Health Care System

We believe that all individuals have the right to control their own bodies. For a woman, this control must include the freedom to determine whether and when she will bear children. We, therefore, wish to go on record in support of legalization of abortion and legal availability of birth control measures to all.

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Dissenting Opinion on Services to the Developmentally Disabled

by John Martin

"The Task Force endorses the inclusion of developmental disabilities services in the comprehensive programs of the unified 51.42 community services boards.

"The Task Force recommends a unified approach to the delivery of services for mental illness, alcoholism and other drug abuse and developmental disabilities by amending Section 51.42 of the Wisconsin Statutes."

In good conscience, I cannot permit myself to be associated in the adoption of these recommendations. Many other parents and some parent groups concerned with the problems affecting our state's 150,000 developmentally disabled citizens will share in my dissent.

These recommendations were adopted based on fragmentary evidence and presented by a committee with special interests in the field of mental health and alcoholism services. While its knowledge of problems affecting the mentally ill and those with behavioral problems has clearly been demonstrated, one must challenge the basis for presenting recommendations in a distinctly different area of concern: developmental disabilities.

In my judgment, the Task Force adopted these recommendations in the absence of adequate factual knowledge that may have permitted a more judicious decision to have been made. For example:

1. Those systems designed to serve the needs of the mentally ill in Wisconsin have historically failed to recognize, comprehend and respond to the problems of the developmentally disabled and their families. This dismal record of failure is briefly alluded to in the Task Force report.
2. Recognizing that the basic needs and expectation of the mentally retarded, cerebral palsied, epileptic and those with other developmental disabilities are in fact more dissimilar than similar to those of the mentally ill, Congress has enacted legislation (P.L. 91–517) which clearly separates services to the developmentally disabled from programs designed primarily for the mentally ill.
3. Despite strong opposition, the 1971 Wisconsin Legislature gave overwhelming support to a measure designed to implement the intent and provisions of the 1970 law. Chapter 322, Laws of 1971, does indeed represent a departure from the concept embodied in Section 51.42, which calls for unified boards serving the mentally ill, mentally retarded, alcoholic and drug abuser. The U.S. Congress and the Wisconsin Legislature, by their actions, agree on at least one issue in the delivery of services. There is nothing inherently virtuous in organizational neatness and a response to demonstrated need takes precedence over administrative neatness.
4. There is no evidence to suggest that the existing state statutes governing, on the one hand, services to the mentally ill and, on the other hand, services to the developmentally disabled cannot and will not be made to work given the resolution of certain funding and administrative problems. It seems inappropriate to move toward the wholesale revision of Section 51.42, supported by the present state administration, when it has had less than one year to demonstrate its strengths and pitfalls.
5. There is no evidence that the concept of integrated services, as envisioned by members of the Task Force, can and will work. To the contrary, the evidence growing out of our experience in Wisconsin and other states clearly suggests a basic inability of programs essentially designed for the mentally ill in effectively meeting the needs of the mentally retarded, to say nothing of the cerebral palsied, epileptic and those with other neurological disorders.

To support these recommendations, even as conceptual notions, requires a degree of faith beyond the present capacity of parents having developmentally disabled children and professionals working in the field. Our vision of the future is blurred, and perhaps understandably, by remembrances of the past.

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DEADLINES FOR 1973 ANNUAL MEETING EVENTS

Jan. 25: Resolutions for the House of Delegates due in Secretary's office. **February:** Publication of major portions of the Annual Meeting program and summaries of resolutions in the *Wisconsin Medical Journal*. **Mar. 24:** Council meeting. **Mar. 25–26–27:** House of Delegates sessions. **Mar. 26–27:** Scientific program.

Doctor, here is your opportunity to communicate with your colleagues, health-care associates, and others . .

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Psychopolitics of Health Planning

How to get a piece of the action!

DAROLD A. TREFFERT, MD
Fond du Lac, Wisconsin

"For one hundred years St. Elizabeth's Hospital has stood on the inspiring heights above the confluence of the Anacostia and Potomac Rivers commanding an unparalleled view of the Capitol of the United States. For one hundred years she has gazed benignly across the river at Congress with true psychiatric patience and understanding. I regret to report that the returning Congressional gaze has not always been so benign. Even though St. Elizabeth has always emerged with a clean bill of health, the Hospital, as far as I can determine, has never been requested to make a return examination of Congress."[1]

CONGRESSIONAL AND POLITICAL GAZE is leveled now not just at St. Elizabeth's, or just psychiatry, but indeed at all of medicine. At both the national and now the state level, health care has been cast nakedly and blatantly into the political arena. In general it can be said that in this state, until recently, health care was not fair game for the political arenas; now it is.

Since politicians are taking a political look at psychiatry and all of medicine, it seems only polite, prudent, and necessary to take a psychiatric look at politics—not as an empty academic exercise but, in fact, as a matter of survival as the game of psychopolitics extends through the national, state, and local political scene, touching all of medicine, public and private.

Definition and Objective

Psychopolitics is a term I use to describe the use of psychology, rather than power, to bring about political change. The objective of psychopolitics is to bring about a politically wise but relatively unpalatable and not necessarily desirable change within a system, yet at the end of that effort to have the people within the system as well as those outside the system feel satisfied and comfortable not only with the changes but also with the politician who brought about those changes.

The use of psychopolitics, rather than pure politics, is used generally for two reasons. First of all, only in a totalitarian state, without accountability through the election process, can the politician afford to bring about change through the use of pure power oblivious to how people affected by that change feel about it. Secondly, the use of psychopolitics is necessary now as politicians begin to invade sensitive areas such as health care, which in this state for example has traditionally remained largely free of political tampering and which, if cast openly into the political arena, might offend public conscience.

Strategy and Tools

The strategy or game plan of psychopolitics is to use a veiled, non-political means (task force, consumer group) to reach and justify a political end (reduced spending, gaining power). The chief tool is the task force or its equivalent which can be, for example, a group of appointed individuals (Marijuana Commission), an existing agency (Institute for Responsive Law) or an individual (Ralph Nader). The task force or its equivalent serves two main purposes:

(1) To establish credentials and objectivity:

The politician, seeking change in most traditionally non-political systems, lacks credentials and expertise to be able to suggest those changes. He needs a reputable and respected person or group of persons to attest to the need for change and to suggest the possible directions of those changes. His own, single efforts might otherwise be easily dismissed or discredited by pointing to his lack of credentials or expertise in the area he is seeking to change, or by labeling his efforts as purely politically inspired. The task force cushions both those accusations.

(2) To act as a public sounding board:

The task force, since it is neither politically nor publicly accountable, can be used as a sounding board to test public opinion and reaction to a variety of proposals to see which are politically viable. The politician himself may be unable to say or do all he wishes initially because of possible untoward backlash, so the task force becomes a useful scout sent out to see where the resistance lies and how large it is. Since task force members are not politically dependent and the task force is set up with a

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Presented at a conference on "The Physician and Comprehensive Health Planning" held November 10, 1972, at the State Medical Society headquarters in Madison.

Doctor Treffert is Superintendent of Winnebago State Hospital, Winnebago, Wisconsin; and is Chairman of the State Medical Society of Wisconsin's Division on Alcoholism and Drug Abuse of the Commission on State Departments.

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time-limited life-span, the task force can make a variety of findings and proposals, however startling or sweeping, without fearing the ultimate reconciling with public accountability that the politician must always bear in mind.

Moves

Move One: The Premise

Move one is to develop a premise which suggests a better way of doing things which, quite incidentally, is a less expensive way. To identify a clear dollar motive in publicly sensitive areas such as welfare, health care or social care, is generally unpalatable and inhumane. The motive rather needs to be couched in terms of doing some things a better way which also happens to be a less expensive way. (Examples: Close the prisons and make exclusive use of probation for all offenders, in place of the incarceration of any, which would not only be better but would be only 1/20 the cost of incarceration; or make all hospital inpatients into office outpatients which necessarily is not only less expensive care, but better care).

Move Two: The Task Force

A task force is appointed, chosen with a deliberate predominance of members who agree with and will support the preconceived premise.

Move Three: Public Hearings and Public Utterances

The task force holds a series of grass roots public hearings so it can be said wide consumer input was used in arriving at final conclusions. During these hearings and their attendant publicity, the task force focuses on emotionally charged key words and phrases about the system it is looking at such as maldistribution, bureaucracy, duplication, overlap, unaccountability, apathy to consumer interests, and exclusion or exploitation of minority groups. The hearings, by their very nature and design, highlight the problems in the system rather than strengths, if any, in the system.

An erosion of public confidence in the system begins and the people within the system become threatened and defensive. (Examples: Highlighting that prisons are dehumanizing and recidivism is high while ignoring that 90% of offenders are already on probation and ignoring whatever public protection functions prisons serve for the really dangerous offender; pointing out that some persons do not have equal and ready access to the health system at all times while ignoring the fact that the overwhelming majority of citizens do have such access.)

Move Four: System Response

Those persons within the system under study become concerned about the utterings of the task force. Personnel within the system who are not comfortable in being a part of a system under attack begin to leave or become defensive, demoralized, angry or pessimistic. Productivity falls and statements of the task force about the quality of the system, therefore, become a self-fulfilling prophecy as the quality of the system does begin to deteriorate. This process is accelerated by funding bodies which withhold or withdraw funds from the existing system, since it is either due to be changed anyway or is in fact outmoded. With depletion in staff and resources, but still carrying out its obligated mission with customers still coming, morale problems add to quality problems in a circular fashion. Public confidence falls even further ripening the prospect of change.

Move Five: The Task Force Reports

The task force puts forth the efforts of its deliberations, which represent an overkill as far as the problem is concerned. Sweeping, drastic changes are proposed going further than even the politician hinted might happen initially. The public is alarmed that what started out as a criticism of the system may end up in a complete toppling of the system. Professional and other groups identified with the system under attack rally to its defense. Personnel working in the system are threatened by the sweeping, drastic changes and are ready, at this point, to accept any less drastic change. (Examples: Close the prisons feeding a public fear that all criminals, even the dangerous ones, will be released into the community; make medicine into a utility regulating who practices where and in what specialty, threatening both the doctor's right to choose his patient and the patient's right to choose his doctor.)

Move Six: Enter the Politician

The psychopolitician, having sensed the public pulse as to what degree of change will be acceptable, tempers the report of the task force, toning it down and indicates that really the entire system is not bad but only parts of it. He proposes changes less radical than those of the task force and proposes to only cut, not delete, the system or to only modify it somewhat rather than to change it drastically. (Example: Close only one or two of the very old prisons still maintaining maximum security capability elsewhere bearing in mind the high priority of public safety; requiring certificate of need or permits to build, etc. only of hospitals and clinics rather than of all individual physicians.)

The personnel or workers in the system are relieved that the changes are not as bad as they thought they would be and are perfectly content and relieved to accept changes they otherwise would conscientiously resist or openly oppose since those changes seriously compromise the quality of the whole system. This is akin to budget padding—deliberately overstating needs so as to gain at least essentials—in reverse, something the social bureaucrat has been accused of for many years by the politician.

The electorate is relieved that the politician, espousing now a common-sense, public syntonic appraisal, is not willing to throw out the baby with the bathwater and proposes far less than the threatened change.

With the system relieved and the electorate reassured not only about the system but about the practicality and levelheadedness of the politician as well, the politician has gained some control over the system and can attend to and achieve the objective of the whole game—dollar savings—which can be funnelled to politically more expedient projects or back to the electorate as tax relief.

While certainly even a dollar savings objective can be honorable, here as elsewhere, one can do the right thing for the wrong reasons. Unfortunately, in the furor of the uproar little attention is paid to the detrimental way in which savings accrue: [1] by a qualitative deterioration in the system, [2] by ignoring the timetable set by the task force for achievement of objectives (10–15 years) and not fully funding on an immediate basis existing systems arguing that they are due to be replaced anyway (even though alternatives have not been provided), and [3] by using professional disagreements—the "let's you and him fight" tactic—stirred up by the task force study as a rationale for delaying any appropriations until the professionals, "the experts," make up their minds. (Examples: not fund the prisons since they are due to be replaced anyway even though such replacement is by a, as yet, non-funded alternative; withdraw support from public inpatient facilities and providing only philosophical, not real or available, alternatives for patients of those hospitals.) (See Appendix II)

* * * *

The game is over in six swift moves.

OUTCOME: Winners and Losers

Who won? Who lost?

Surfacewise it appears that everyone has won. The personnel in the system have won a relative victory in that things are not as bad as they fantasied they might be. The electorate likewise has won, with relative relief to see that seemingly only the good of the system has endured and the bad has been ferreted out. The politician has won in that he has achieved politically an expedient objective—dollar savings—for budget diversion or budget relief which is always useful political fodder.

On closer examination, however, it becomes evident there have been some losers as well and also some of the winners, having gained in the short-term, are the really longer-term losers. The obvious, absolute losers are the patients or clients—the real consumers—still in the system now voiceless victims of a political, deteriorating, stalled, and underfunded system. The personnel in the system find the feeling of "what-might-have-been" relief short-lived as the system experiences its inability now to recruit and to retain the more capable people, or at least to maximally actualize them, because of eroded public confidence in the system and the attendant low morale and low incentive. The task force itself has lost also, having been somewhat betrayed and certainly used. Finally, the public, a short-term winner, with a bit of immediate tax relief, loses and pays much more in the long run as they have witnessed the forfeiture of long-term objectives, goals, and responsibility—quality and integrity—for short-term expediency.

Only the politician finally wins since his commitment to change from the beginning was, and necessarily is, only to short-term objectives. Change is evaluated not on the basis of whether the changes brought about are better in the long run, but rather are those changes less expensive at least in the short run.

The task the public has faced with politicians from the beginning of time has been to prevent them from forfeiting long-term objectives—the public good—for short-term goals—power.

Problems with Psychopolitics

There is no system, including medicine, that can or should remain the same with the world changing all around. Neither is there any system, including medicine, that need not change in order to correct its differences and its shortcomings. I support wholeheartedly change and improvement in the whole health delivery system. My quarrel is with how that change is to be brought about.

Changing behavior of a system is no different than changing behavior of a person, for a system, after all, is simply a congregate of a whole lot of persons. I submit there are constructive, productive methods to effect change in people—or in systems—and there are destructive, counter-productive methods. Psychopolitics falls into the latter category.

The basic objection to psychopolitics is that it is fundamentally dishonest. It seeks to do the right thing (bring about change) but for the wrong reasons (dollar or power motive). In shaping human behavior, a real and genuine concern for the person—or system—one is dealing with is paramount in the long run. The patient, whose therapist is interested in the patient's pocketbook and not in the patient, soon senses that and it significantly gets in the way of the patient's getting well or changing. An analogous situation where the politicians are concerned about the system's pocketbook—and not genuinely in the system itself (its quality, its viability)—stands in the way of the system changing.

Secondly, the scare tactic—"it could be worse"—ultimately offends, betrays, and angers. The obstetrician–gynecologist who makes each of his patients feel as if each parturition is indeed a walk through the valley of the shadow of death, does end with a grateful, relieved, patient when it is all over. But in that whole process, he has cheapened it, and cheated the patient of her mature participation in the whole project and some of her pride and accountability

for it. In my field, working in partnership with the patient in his own change, rather than doing change to him—if that is at all really possible—is a more mature way of doing business together. I get less of the credit, less of an ego-biscuit for me, but the change is more solid, more accepted, more cathected, and more real.

Finally I have been unimpressed with trying to change someone—or some system—by only exposing and dwelling on that person's weaknesses rather than his strengths. One doesn't mold a person, or raise a child for example, with only criticism. In trying to effect change one first tries to engage the person in that effort and once having done so, while certainly dealing with weaknesses and hangups, one also builds even more so on strengths and potential.

Change is not something one does *to* someone, it is something one does *with* someone. The impulse to give advice—whether from a doctor or a task force—is irresistible but the ability to ignore advice is universal *unless* the person one is advising is brought into the whole process and is then not a participant/observer, but a participant/participant.

A Better Way of Doing Things

Unfortunately most of the game here has already been played. It would be better if the whole process would always begin more maturely avoiding the pitfalls outlined above. It would be better if truly objective study groups would be set up representing diverse points of view open to honest inquiry avoiding each group member's own little ego-trip. It would be better if professionals would always resist being drawn into the "let's you and him fight" dynamic.

At this point such protestation is not helpful in a preventative way for the present health systems study. A variety of proposals, and some 200 legislative bills, will evolve from that effort. The task now—if we wish to participate in our change rather than merely observe it—is to become involved. Involved not with complaints or platitudes, memories or traditions, hurts or fears, resignation or apathy, but with real action such as developing meaningful cost: benefit ratios; real performance indicators; tangible quality control of practitioner and practice. We need to point out to the patient, not just to the politician, what is at stake: that the cure may be worse than the disease. (See Appendix I)

In my field the strongest, clearest spokesman for the mentally ill are they themselves and their relatives, not the psychiatrists. The mother of a mentally ill child can do more on behalf of mentally ill children at a legislative hearing than all the superintendents in the state. In general patients speak highly of their own physician but poorly of all of medicine. Likewise the politician probably esteems and values his own physician or those he knows but views not so kindly organized medicine. To mobilize that segment—the silent majority of consumers—our patients—so that both they and we can evolve a viable, worthwhile system of health care together seems to me to be our task. Participation in this needs to extend beyond the consultation room, to community participation, to local and regional health planning and to the legislative halls, not by our lobbyist, but by us.

Summary

Psychopolitics is the use of psychology, rather than pure power, to bring about politically useful but somewhat unpalatable and not necessarily positive change in a publicly sensitive area in a manner that ultimately has both the system and the public satisfied and comfortable with the changes and with the politicians who brought about those changes. By use of a task force, or its equivalent, the politician can sound public policy, establish credentials, yet escape public accountability for changes too sweeping or resulting in system deterioration.

Clearly in medicine, as in any other system, change is constantly required at an ever-accelerating rate. Hopefully by understanding the game of psychopolitics, exposing it, and using some of the counter-strategy suggested, politicians will be forced to use neither psychology nor power to bring about needed changes, but rather will use instead honest inquiry and persuasion.

I have no delusions that this simple treatise, this instant analysis of psychopolitics, will change the course of that which has already transpired here and elsewhere.

But like a poor football call by an official on Sunday, while instant replay on Monday Evening Football does nothing to change the call itself, instant replay does make the spectators, the participants and even the officials more alert, more astute, more objective and maybe even in some cases, more honest.

REFERENCE

1. Lebensohn ZM: "Contributions of St. Elizabeth's Hospital to a Century of Progress" in *Centennial Papers of St. Elizabeth's Hospital,* Baltimore, Waverly Press, 1956.

APPENDIX

I. The British government has proposed "sweeping administrative reforms in Britain's system of socialized medicine to meet growing criticism of bureaucracy and shortcomings in the service," the *New York Times* has reported. It added that "the reforms, the first since the national health service came into being, amount to a complete structural shake-up of a system cited often as one of the finest examples of socialized medicine." The proposals, "which will undoubtedly be approved by Parliament," are aimed at decentralizing the health service and giving the public a "vigorous local voice," NHS officials said. Recently the service has been criticized for neglect of the aged, handicapped and mentally ill, the long waiting time for major operations, refusal of some doctors to make home visits and lack of adequate medical facilities in many areas.

—*Blue Cross Wire Service Digest,* August 7, 1972

II. New York State's announced intention of discouraging admission of chronic psychotic and geriatric patients to state hospitals has drawn fire from the hospital committee of APA's New York County District Branch and from a group of researchers. Both the committee and the researchers deplore the administrative decision to suppress admissions, arguing that alternative facilities for the patients

are not yet available in the communities they come from. "There is a serious crisis in New York City regarding the care of chronic patients." Edwin Robbins, MD, director of psychiatric emergency and admission services at Bellevue Hospital in New York and a member of the hospital committee, recently wrote an unpublished paper on "the problems which have arisen as people have been discharged into scant or non-existent local programs in Manhattan."

"This drop in admissions was largely the result of administrative decisions, which were relatively independent of clinical considerations."

Ostensibly, the state ordered the policy change for the therapeutic value for mental patients, say the authors, but "it is conceivable that the policies of New York were accelerated because the state assumes full financial responsibility for patients treated within the state hospital system, but share costs with local communities for those discharged or not admitted." Whatever the reason the committee believes that there "is a serious crisis" in New York as a result of this policy.

—*Psychiatric News*, Vol. VII, No. 19, October 4, 1972 □

MALPRACTICE PENALTIES FOR THE UNLICENSED

Section 448.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.22 reads as follows:

"Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1973–June 30, 1973

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN—BUREAU FOR CRIPPLED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	
Manitowoc	Feb. 26–27	W. F. Schneider, MD
Kenosha	Mar. 6	L. T. Schlenker, MD
Kenosha	Mar. 7	C. A. Sattler, MD
Stevens Point	Mar. 21	F. W. Reichardt, MD
Racine	Mar. 28	C. W. Christenson, MD
Racine	Mar. 29	M. W. Nelson, MD
Sheboygan	Apr. 4–5	J. J. Van Driest, MD
Rhinelander	Apr. 11–12	H. I. Okagaki, MD
Lancaster	May 2	J. D. Heiden, MD
Darlington	May 3	R. C. Wixson, MD
Chippewa Falls	May 8	J. M. Huffer, MD
Eau Claire	May 9	G. L. Lucas, MD
Superior	May 23	J. G. Heisel, MD
Ashland	May 24–25	W. T. Brodhead, MD

FOR: Clinics conducted by the Bureau for Crippled Children of the Division for Handicapped Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: Referral forms may be obtained from the Division for Handicapped Children and should be requested well in advance of the clinic date. Referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: As of January 1, 1972 we no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

ADDRESS CORRESPONDENCE: Division for Handicapped Children, 126 Langdon St., Madison, Wis. 53702.

TABLE 1—*Wisconsin Yearly Births and Estimated Congenital Heart Disease: 1967–1971*

Year	Total Births	Estimated Number With Congenital Heart Disease (8/1000)
1967	75,797	606
1968	74,257	594
1969	74,324	595
1970	77,455	620
1971	71,976	576
Five-Year Average: 602 per year		

SOURCE: *Public Health Statistics—Wisconsin*, Division of Health, Department of Health and Social Services.

as well as children with documented acute rheumatic fever will be admitted to the registry. Children dying with cardiac disease (proven by autopsy) will also be included. It is hoped that this information will eventually be put into a computer and will furnish information regarding incidence, treatment, survival, and other vital statistics about pediatric cardiovascular disease. In addition, it will provide the necessary statistics for future planning for medical needs and facilities.

Pathology Consultation Service

Any physician caring for a pediatric patient who dies due to cardiac disease and has an autopsy will be invited to request pathological consultation from the Center. This will be especially valuable in those rare complex cardiac cases which are seldom seen by pathologists not in large centers. If the heart specimen is submitted to the Center, it will be analyzed by the cardiac pathologist and a comprehensive written report will then be mailed to the physician requesting consultation. In addition, the entire collection of pediatric heart specimens will be available for examination to any physician in Wisconsin interested in analyzing them at the Milwaukee Children's Hospital.

Additional Activities

Plans are in progress to establish a streptococcal detection center for patients living in the inner city of Milwaukee. It is also hoped that an announcement relating to formation of a pediatric hyperlipidemic profile screening program to be part of the Center will be made within a year. Finally, psychiatric consultations for children who have cardiac disease, as well as their parents, will be expanded and the use of the "group technique" for therapy is anticipated.

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3. Carlgren LE: Incidence of congenital heart disease in Gothenburg, *Proc Assoc Europ Paed Cardiol* V:2, 1969.
4. Berendes H: Structure and scope of the collaborative study of cerebral palsy, mental retardation and other neurologic and sensory disorders of infancy and childhood, *Research Methodology and Needs in Perinatal Studies*, Springfield, Illinois, Charles C. Thomas, 1966.
5. Fyler DC: Cardiac catheterization, cardiac surgery and the newborn infant—1969, *Pediatrics* 44:1, 1969.
6. Varghese PJ, et al: Cardiac catheterization in the newborn—experience with 100 cases, *Pediatrics* 44:24, 1969.
7. Barratt-Boyes BG, Simpson M, and Neutze JM: Intracardiac surgery in neonates and infants using deep hypothermia with surface cooling and limited cardiopulmonary bypass, *Circulation* (Suppl I) XLIII and XLIV: 125, 1971. □

WILLIAMS–STEIGER OCCUPATIONAL SAFETY AND HEALTH ACT

The new act will bring increased demands to employers, employes, physicians, and other health personnel. More physicians may be approached by small companies wanting medical consultation services. The Division of Health, State Department of Health and Social Services, offers the following helpful information.

Regional Administration for Wisconsin is in District 5, with Chicago offices for both the Department of Labor and the Department of Health, Education, and Welfare.

For information about the Federal Occupational Health and Safety Standards, contact the Department of Labor:

Edward E. Estkowski, Administrator
Occupational Safety and Health Administration
300 South Wacker Drive, Room 1201
Chicago, Illinois 60606 (312) 353–4716

Area Office, Milwaukee, Wisconsin:
Robert Hanna, Director
Sheraton–Schroeder Hotel, Room 906–907
Milwaukee, Wisconsin 53203 (414) 271–7250

Information about record-keeping requirements under OSHA may be obtained from:
William E. Rice, Regional Director
Bureau of Labor Statistics
300 South Wacker Drive (312) 353–7235 for specific information
Chicago, Illinois 60606 (312) 353–7253 for recorded questions

New State and Community Services Help Developmentally Disabled Persons

New services to help developmentally disabled persons, their families, and professionals working with them are developing rapidly throughout Wisconsin. Most are local services which have developed as a result of the present trend towards community sponsored programs for the developmentally disabled; others are state services. In addition traditional state and local services for the developmentally disabled have expanded in the past five years, so that today most communities in the state have some specialized programs for the developmentally disabled.

On the Community Level

Some communities have established information and referral services to provide information about developmentally disabled and make referrals to appropriate sources of help. Information and referral service staff persons are well acquainted with local, regional, and state resources for the developmentally disabled and their families, and can direct parents and others to the appropriate agency. At present there are 28 information and referral services in as many counties. They are located in day services centers (day care), county departments of social services, public health nursing offices, mental health clinics, and sheltered workshops.

Home training services are also available in some communities. A home trainer visits families to help parents acquire the knowledge and skills needed to help their developmentally disabled children become as self-sufficient as possible. Behavior and self help skills, such as toilet training, dressing, walking, and feeding, are the usual problems with which the home trainer helps the parents. The home trainer is also alert to additional difficulties which need the attention of other professionals in the community. There are currently 54 home trainers in 42 counties in Wisconsin. They are located in day services programs, school systems, sheltered workshops, county departments of social services, and mental health clinics.

In the past five years traditional local programs have increased in number and expanded to serve a wider range of children and adults. Day service boards in many communities administer activity and sheltered workshop programs for developmentally disabled adults in addition to the regular day services programs for children and adults.

Special education classes also have expanded and include programs for trainable and educable youngsters from elementary through high school. Work study programs help educable high schoolers learn work skills while completing their formal school training.

On the State Level

With the recent establishment of Development–Evaluation Centers (DECs) at Northern and Southern Colony and Training Schools (Central Colony's DEC is nearly ten years old) diagnostic and clinical and prevocational evaluational services are available to Wisconsin citizens thought or known to be developmentally disabled. Each DEC serves a designated section of the state. All that is needed to initiate evaluation procedures is a letter or telephone call from a parent, social worker, or physician to the appropriate DEC. Prior to actual colony placement a licensed Wisconsin physician must endorse the referral. The DECs at each of the three colonies are staffed by physicians, psychologists, social workers, nurses, and para-professionals. The DECs also help communities establish and maintain specialized local services for the developmentally disabled.

The Coordinated Information Center on Mental Retardation (CIC–MR), comprised of nine statewide agencies,* is a centralized source of information on the developmental disabilities. It pulls together and supplements generalized information materials on the developmental disabilities and available programs and services throughout the state. By facilitating communications among agencies and increasing public understanding of the developmentally disabled, the CIC–MR seeks to help pave the way to the more effective and efficient development, delivery, and use of services.

For names and addresses and further information on resources available for the developmentally disabled in Wisconsin and for the booklet, *For the Retarded: A Guide to Services in Wisconsin,* write the CIC–MR, P.O. Box 777, Madison, WI 53701.

*Governor's Committee on Employment of the Handicapped; State Department of Health and Social Services—Division of Family Services, Division of Health, Division of Mental Hygiene, Division of Vocational Rehabilitation; State Department of Public Instruction—Division for Handicapped Children; University of Wisconsin—Rehabilitation Research and Training Center in Mental Retardation; Wisconsin Association for Retarded Children; and Wisconsin State Employment Service. □

Prepared by the Education-Information Section of the Division of Mental Hygiene, Wisconsin Department of Health and Social Services.

STATEWIDE GONORRHEA SCREENING PROGRAM

with recommendations of the Wisconsin Division of Health on

Criteria and Techniques for the Diagnosis of Gonorrhea

and

Treatment of Gonorrhea

Prepared by H. Grant Skinner, MD, MPH, Chief, Section of Communicable Diseases, Department of Health and Social Services, Division of Health, State of Wisconsin, PO Box 309, Madison, Wisconsin 53701.
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TRADITIONALLY, gonorrhea control programs are based on the assumption that the infected male would report for treatment and that he would be a link to his contact, an asymptomatic female. Recent research indicates that this assumption is wrong. Not all infected males have symptoms that bring them to treatment. Therefore, it is very difficult to trace enough of the infected females through their male contacts to have much impact on the control of the disease.

Studies indicate that the infected women are in the age group 15 to 35 years. They are infected at the rate of 0 to 9%. They receive their health care from private physicians. Since they frequently have pelvic examinations, the State Division of Health is asking their physicians to do routine cervical cultures whenever a pelvic examination is done. Culture materials are now available to all physicians without cost.

Every physician can use the State Laboratory of Hygiene's mailing service. This involves the use of the CO^2-containing culture bottles with media—Transgrow. The gonorrhea culture test kits are available from the State Laboratory of Hygiene; call 608/262–1293, or write to the State Laboratory of Hygiene, 465 Henry Mall, Madison, Wisconsin 53706. There is no charge for these kits.

In addition, certain physicians, depending on the location of their office and the number of specimens, can use one of the following health departments or private laboratories. Some supply Thayer–Martin media, and others have Transgrow available. Pickup services are available in conjunction with these programs. They are financed through a grant from the federal government.

Laboratory	*Serving Physicians in:*	*For Information, call:*
Physician's Medical Laboratory	Appleton Area	414/739–3667
Beloit Memorial Hospital	Beloit	608/364–5131
Eau Claire City–County Health Dept.	Eau Claire	715/832–8331
Green Bay Health Dept.	Green Bay	414/437–7611
Kenosha Health Dept.	Kenosha	414/658–4811
La Crosse Health Dept.	La Crosse	608/782–5493
Madison Health Dept.	Madison	608/266–4842
Marshfield Clinic	Central and Northern Wis.*	715/387–1741 ext. 340
Milwaukee Health Dept.	Milwaukee Area	414/258–8323
Racine Health Dept.	Racine	414/634–7111
Sheboygan Health Dept.	Sheboygan	414/457–5011
Superior Health Dept.	Superior	715/394–0296

* Pickup and delivery services are now being established along several routes.

The statewide increase in gonorrhea incidence has resulted in a renewed professional interest in the diagnosis and treatment of this disease. Accordingly, the Division of Health offers the following recommendations:

Criteria and Techniques for the Diagnosis of Gonorrhea

Criteria

WOMEN

1. *Screening Programs*

   To detect asymptomatic gonorrhea in women, a culture specimen should be obtained from the cervix and inoculated on a Thayer–Martin(TM) culture plate or in a Transgrow bottle. *Neisseria gonorrhoeae* grows on either of these media and produces colonies that react positively to the oxidase test and yield Gram-negative diplococci. This provides sufficient criteria for a diagnosis of gonorrhea.

2. *Women Suspected of Having Gonorrhea*

   For women suspected of having gonorrhea because of present complaints or having been named as sexual contacts to diagnosed male gonorrhea cases, culture specimens should be obtained from both the cervix and the anal canal and inoculated on separate Thayer–Martin(TM) culture plates or in separate Transgrow bottles.

3. *Test-of-Cure Cultures*

   For test-of-cure, culture specimens should be obtained from the cervix and inoculated on either TM or Transgrow medium.

Note: Gram-stained or fluorescent antibody stained smears are *not recommended* for the diagnosis of gonorrhea in women.

MEN

1. Microscopic demonstration of Gram-negative, intracellular diplococci on smear of a urethal exudate constitutes sufficient basis for a diagnosis of gonorrhea. Prepare smear by *rolling* swab on slide.
3. Whenever a patient has a urethral exudate and Gram-negative diplococci cannot be identified on direct smear, a culture specimen should be obtained from the anterior urethra and inoculated on Thayer–Martin(TM) or Transgrow medium. A sterile loop should be used to obtain the specimen.
3. When a test-of-cure or a test for incubating gonorrhea is needed, a culture specimen should be obtained from the anterior urethra and plated on either medium.
4. In *homosexuals,* an additional culture specimen should be obtained from the anal canal and pharynx, and be inoculated on TM or Transgrow medium.

Note: Fluorescent antibody staining of smears of urethral exudates is not recommended *to diagnose gonorrhea.*

Techniques

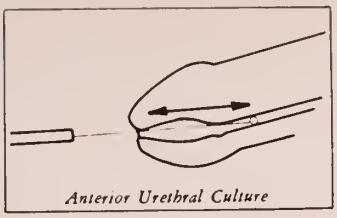
I. *OBTAIN CULTURE SPECIMEN*

WOMEN

1. CERVICAL CULTURE—the best site to culture.
   a. Moisten speculum with warm water; do NOT use any other lubricant.
   b. Remove cervical mucus, preferably with a cotton ball held in ring forceps.
   c. Insert sterile cotton-tipped swab into endocervical canal; move from side to side; allow several seconds for absorption of organisms to the swab.
2. ANAL CANAL CULTURE (also called "rectal culture")—most likely site to be positive when cervix is negative.

   Note: This specimen can easily be obtained after the cervical specimen without changing patient's position and without using anoscope.

   a. Insert sterile, cotton-tipped swab approximately one inch into the anal canal. (If swab is inadvertently pushed into feces, use another swab to obtain specimen.)
   b. Move swab from side to side in the anal canal to sample crypts; allow several seconds for absorption of organisms to the swab.


Anterior Urethral Culture

MEN

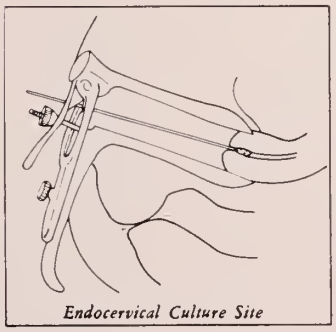
1. URETHRAL CULTURE—indicated when Gram stain of urethral exudate is not positive, in tests-of-cure, or as test for incubating gonorrhea.
   a. Use sterile bacteriological wire loop to obtain specimen from anterior urethra by gently scraping the mucosa.
2. ANAL CANAL CULTURE—These can be taken in the same manner as for women.

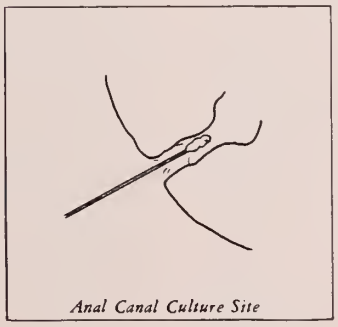
II. *INOCULATE THAYER–MARTIN MEDIUM* or *TRANSGROW MEDIUM*

THAYER–MARTIN PLATES

A. Roll swab directly on Thayer–Martin(TM) medium in a large "Z" pattern to provide adequate exposure of swab to plate for transfer of organisms.
B. Cross-streak immediately with a sterile wire loop, preferably in the clinic. If not done previously, cross-streaking should be done in the laboratory.
C. Place culture in a candle jar as soon as possible.
D. Begin incubation of plates the same day.

   Note: All media should be at room temperature when inoculated.


Endocervical Culture Site


Anal Canal Culture Site

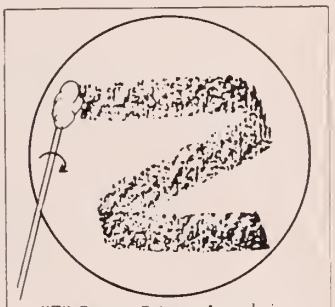
TRANSGROW BOTTLES

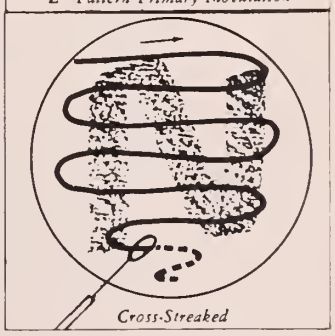
A. Inoculate specimens on the surface of Transgrow medium as follows:

   CAUTION: Keep neck of bottle in elevated position to minimize CO_2 loss.

   1. Remove cap of bottle only when ready to inoculate medium.
   2. Soak up all excess moisture in bottle with specimen swab and then roll swab from side to side across medium, starting at the bottom of the bottle.

B. When possible, incubate the Transgrow bottle in an upright position at 35–37° C for 16–18 hours before mailing and note this on accompanying request form. Resultant growth survives prolonged transport and is ready for identification upon arrival at the laboratory.


"Z" Pattern Primary Inoculation


Cross-Streaked

C. Package the capped Transgrow bottle and request form in a suitable container to prevent breakage and immediately transport to a central bacteriologic laboratory by postal service or other convenient means.

D. At the laboratory, preincubated Transgrow bottles will be examined immediately for N. gonorrhoeae; other bottles will be incubated at 35–37° C for 24–48 hours and examined.

Recommended Treatment Schedules for Gonorrhea and Syphilis

UNCOMPLICATED GONORRHEA:

Men or Women: 4.8 million units of aqueous procaine penicillin G administered intramuscularly at two sites during one visit, plus 1 gram of oral probenecid given at least 30 minutes prior to the penicillin injections.

WHEN PENICILLIN OR PROBENECID ARE CONTRAINDICATED OR FOR RETREATMENT:

Men: 2 grams of spectinomycin in one intramusclar injection. Women (Not pregnant): 4 grams of spectinomycin in one intramuscular injection. Pregnant women: 8 grams of erythromycin administered 2 grams per day for 4 days.

PROPHYLACTIC TREATMENT:

Patients with known exposure to gonorrhea should be treated as above.

COMPLICATIONS:

Although treatment of complications (gonococcal salpingitis, bacteremia, arthritis, etc.) must be individualized, repeated large parenteral doses of aqueous crystalline penicillin G have been shown to be effective. The efficacy of alternate antibiotic regimens is unproven.

LOOK FOR CONCOMITANT SYPHILIS!

All gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. If this serologic test for syphilis is negative, and the patient was treated with the recommended penicillin schedule, then no further serologic tests for syphilis are necessary. Patients treated with spectinomycin, or erythromycin should have a followup serologic test for syphilis each month for 4 months to detect syphilis that may have been masked by treatment for gonorrhea.

Consent Forms for Physicians

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; or tel. 608/257–6781.

Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms.

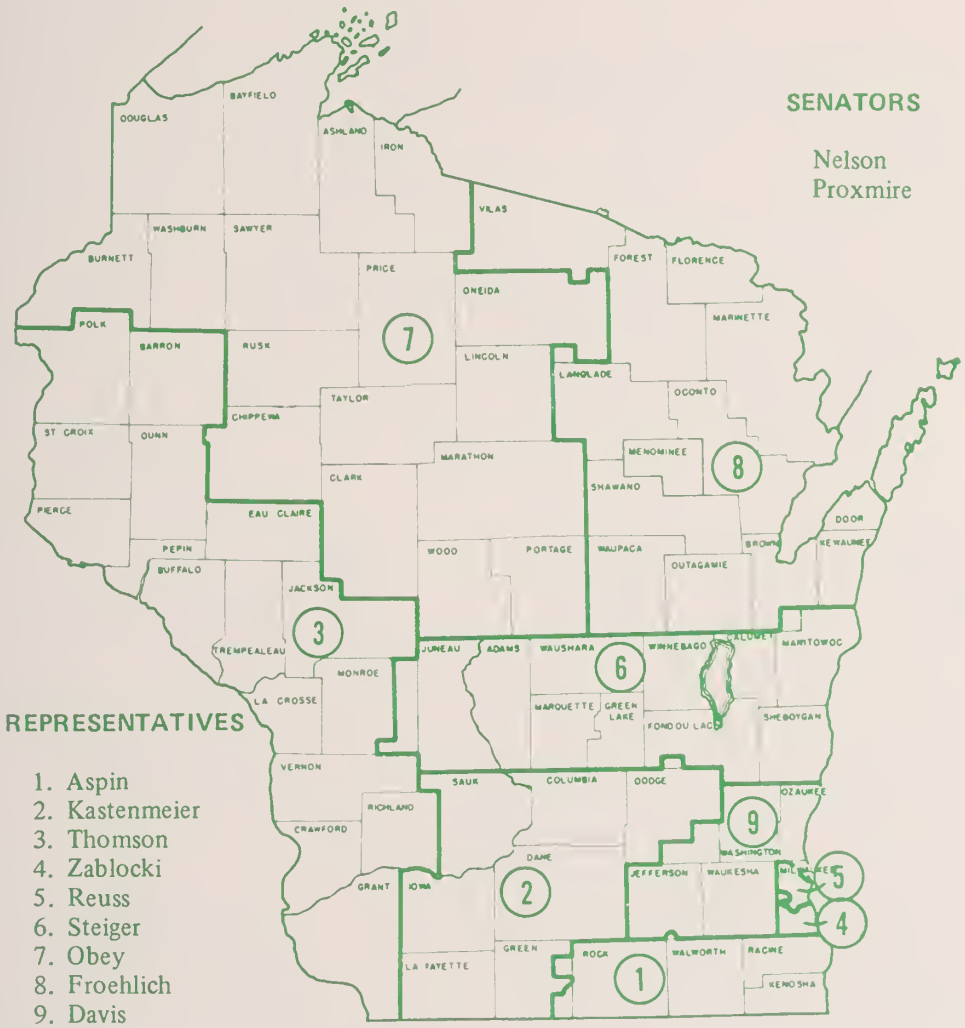
These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

Directory of the 1973 Wisconsin
LEGISLATIVE AND CONGRESSIONAL DISTRICTS

Prepared by the Wisconsin Taxpayers Alliance
335 W. Wilson Street
Madison, Wisconsin 53703

Wisconsin Congressional Districts



SENATORS

Nelson
Proxmire

REPRESENTATIVES

1. Aspin
2. Kastenmeier
3. Thomson
4. Zablocki
5. Reuss
6. Steiger
7. Obey
8. Froehlich
9. Davis

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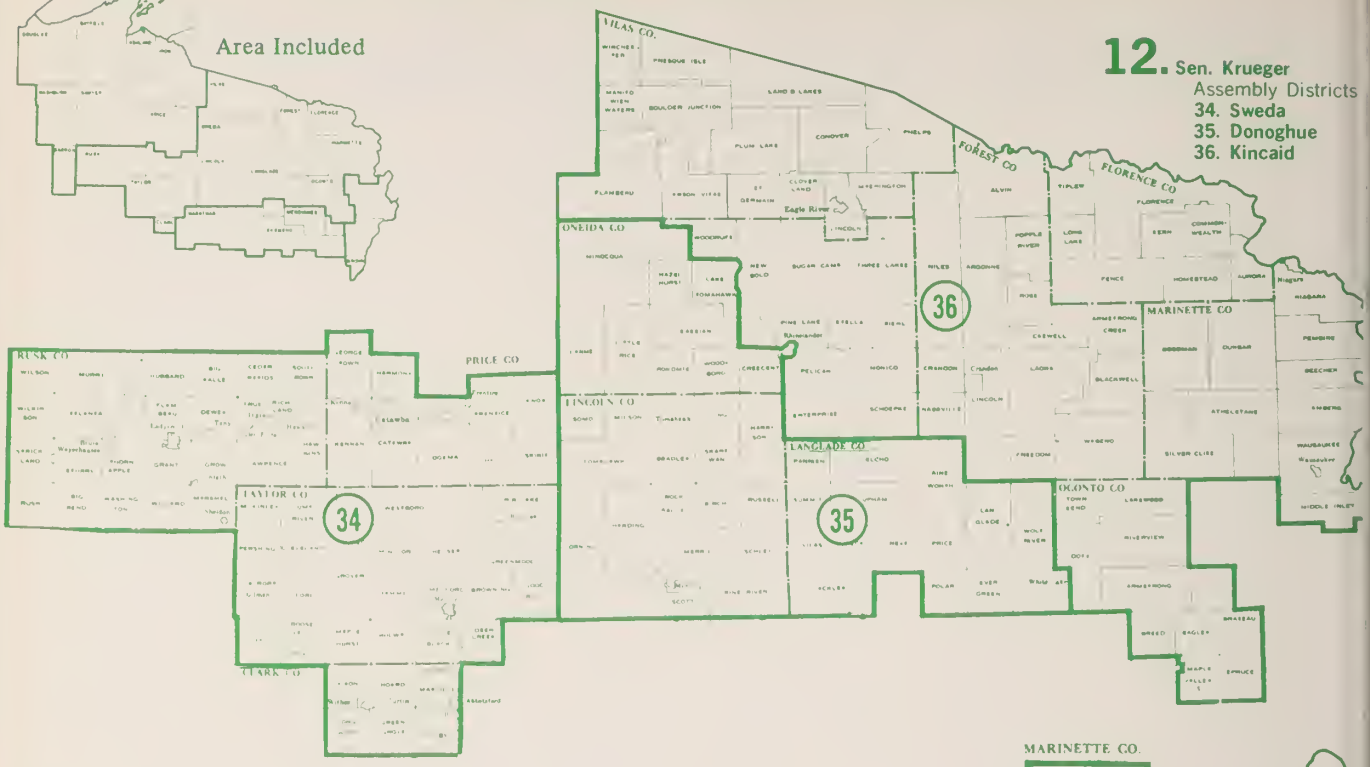
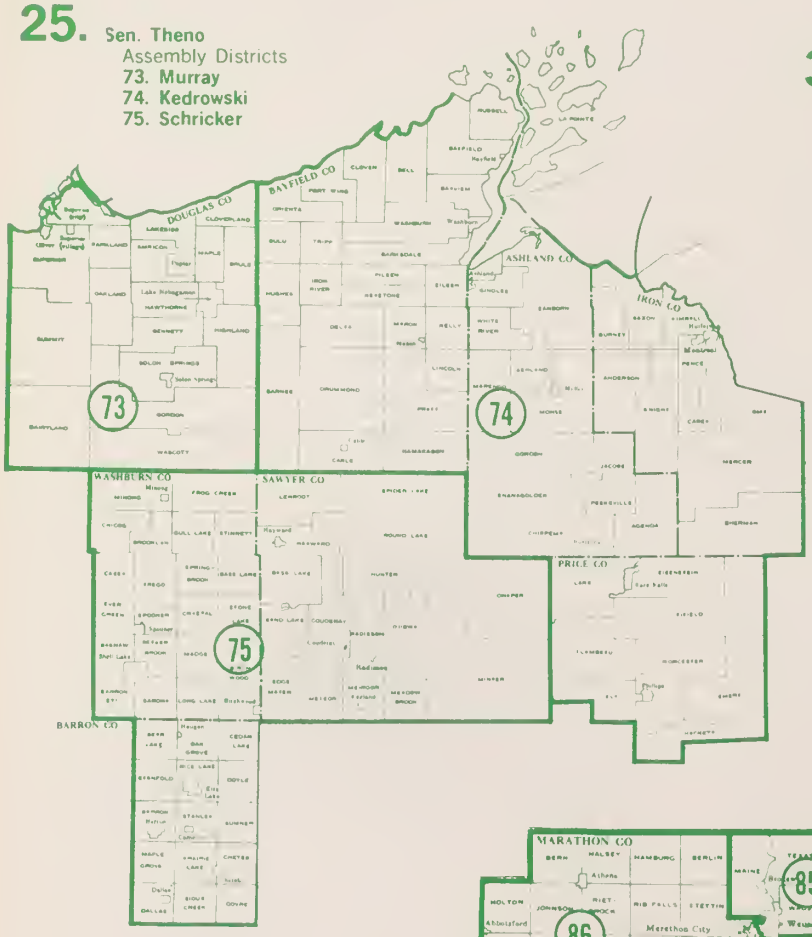
Northern Senate Districts 12, 25, 29, 30

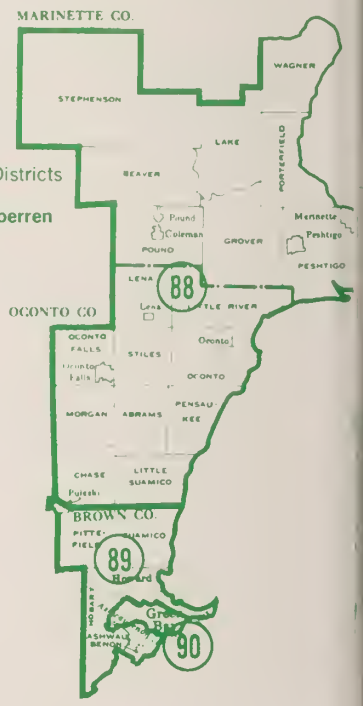
12. Sen. Krueger
Assembly Districts
34. Sweda
35. Donoghue
36. Kincaid



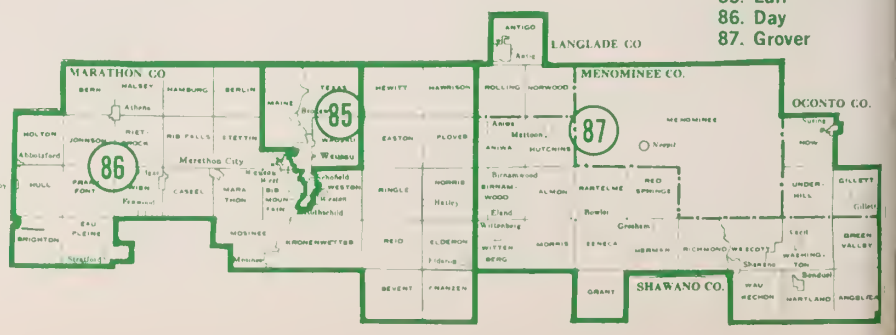
25. Sen. Theno
Assembly Districts
73. Murray
74. Kedrowski
75. Schricker



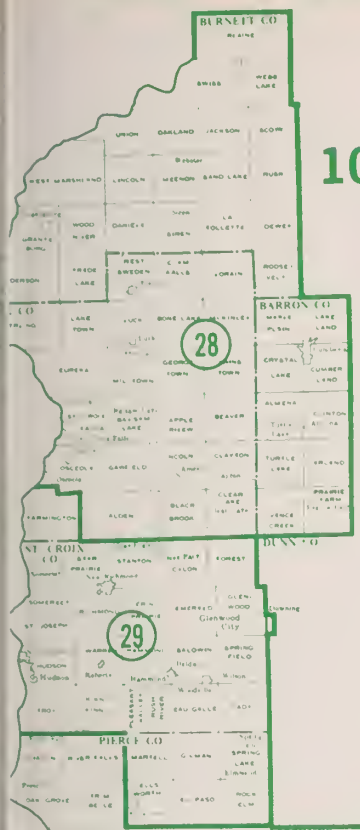
30. Sen. LaFave
Assembly Districts
88. Matty
89. Vanderperren
90. Quinn



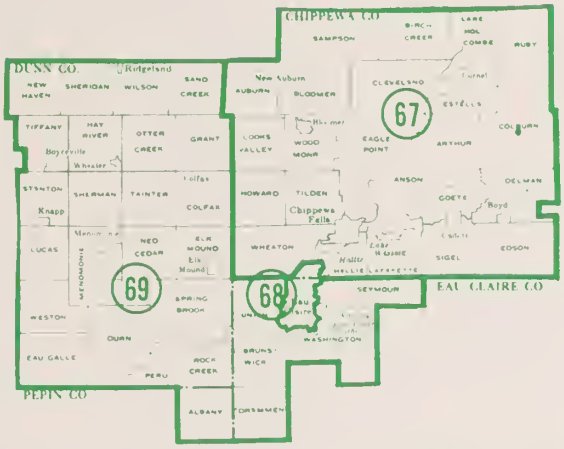
29. Sen. Chilsen
Assembly Districts
85. Earl
86. Day
87. Grover



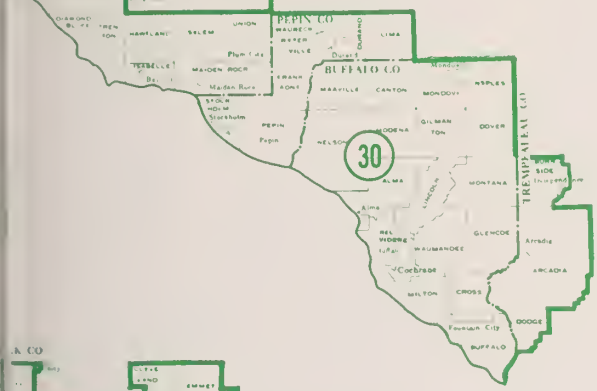
Northwestern and Central Senate Districts 10, 14, 23, 24, 31

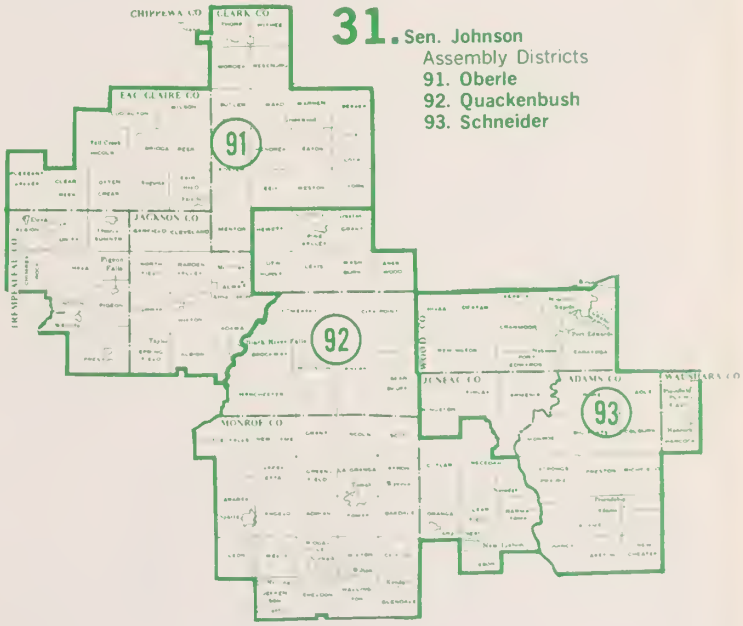


10. Sen. Knowles
Assembly Districts
28. Dueholm
29. Mohn
30. Early

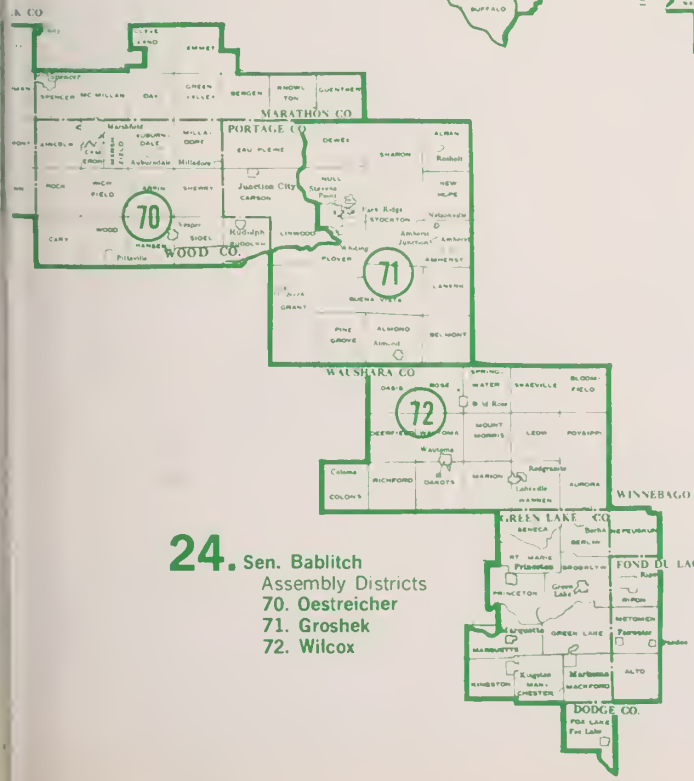


23. Sen. Peloquin
Assembly Districts
67. Willkom
68. Looby
69. Baldus

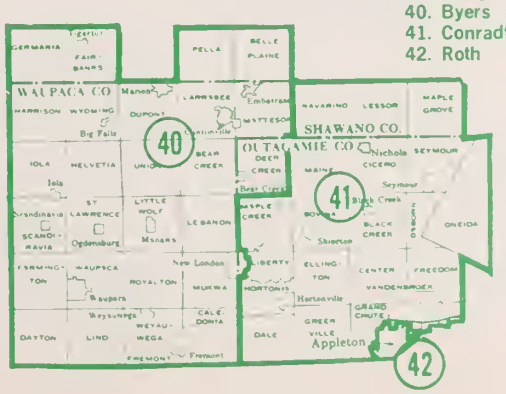




31. Sen. Johnson
Assembly Districts
91. Oberle
92. Quackenbush
93. Schneider



24. Sen. Bablitch
Assembly Districts
70. Oestreicher
71. Groshek
72. Wilcox



14. Sen. Lorge
Assembly Districts
40. Byers
41. Conradt
42. Roth

Eastern Senate Districts 1, 2, 18, 19, 20, 21, 22, 33

Area Included

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2. Sen. Petri
Assembly Districts
4. Gower
5. Rogers
6. Hephner

19. Sen. Steinhilber
Assembly Districts
55. Ellis
56. Flintrop
57. Bradley

1. Sen. Martin
Assembly Distric
1. Swoboda
2. Lallensack
3. Bolle

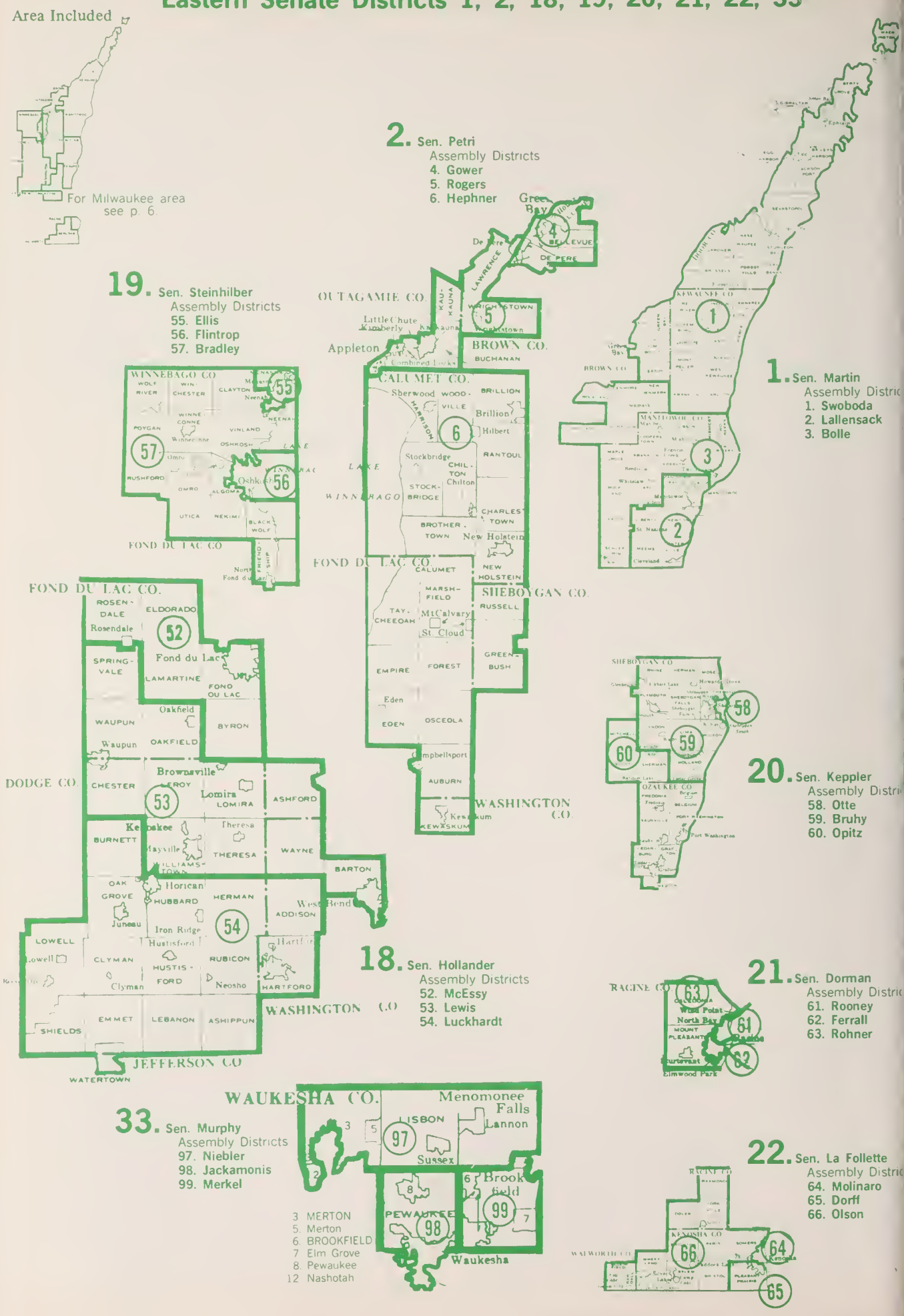
20. Sen. Keppler
Assembly Distri
58. Otte
59. Bruhy
60. Opitz

18. Sen. Hollander
Assembly Districts
52. McEssy
53. Lewis
54. Luckhardt

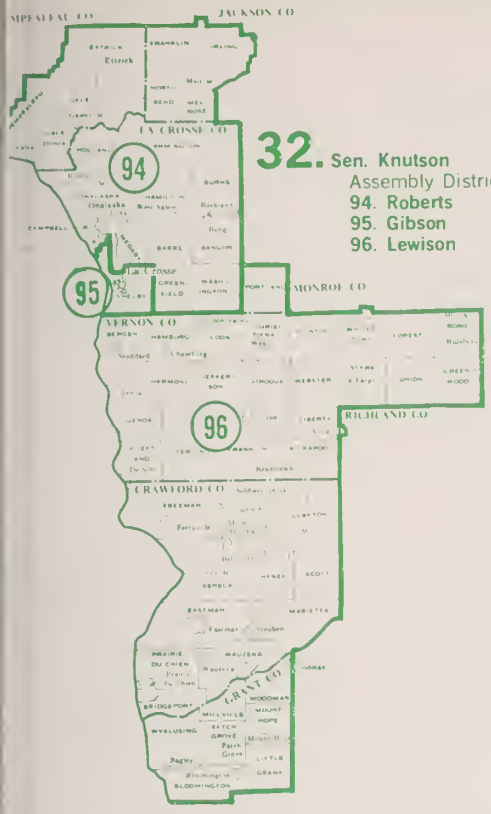
21. Sen. Dorman
Assembly Distric
61. Rooney
62. Ferrall
63. Rohner

33. Sen. Murphy
Assembly Districts
97. Niebler
98. Jackamonis
99. Merkel

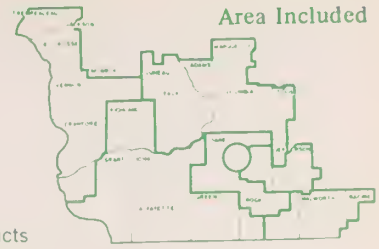
22. Sen. La Follette
Assembly Distric
64. Molinaro
65. Dorff
66. Olson



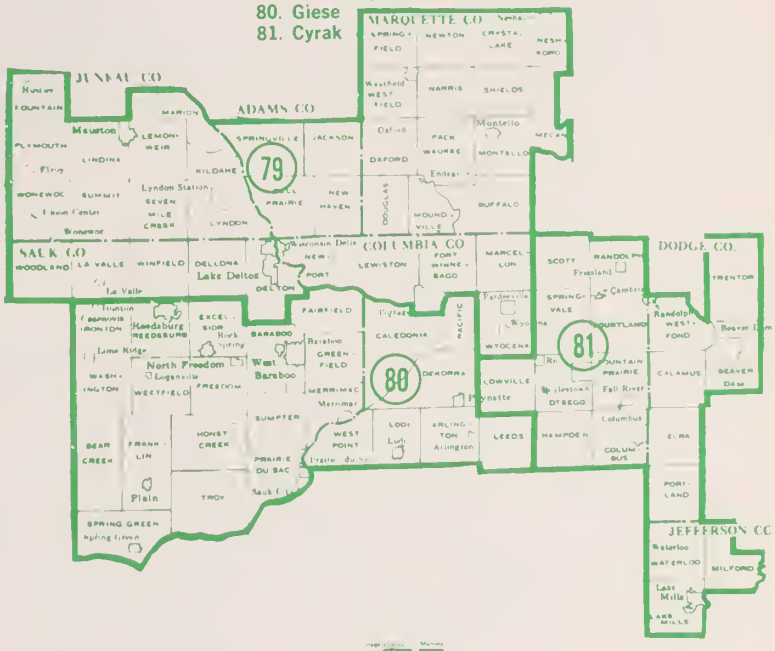
Southern and Western Senate Districts 13, 15, 16, 17, 26, 27, 32

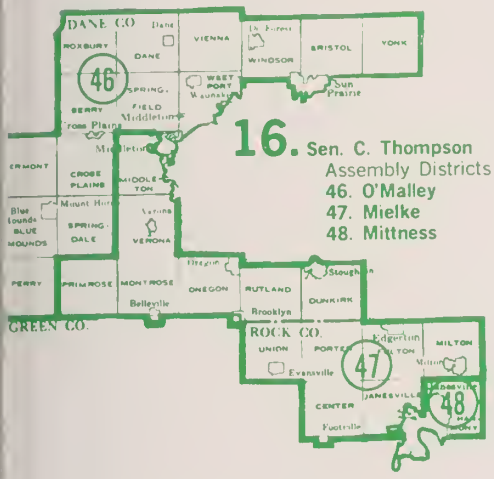


32. Sen. Knutson
Assembly Districts
94. Roberts
95. Gibson
96. Lewison

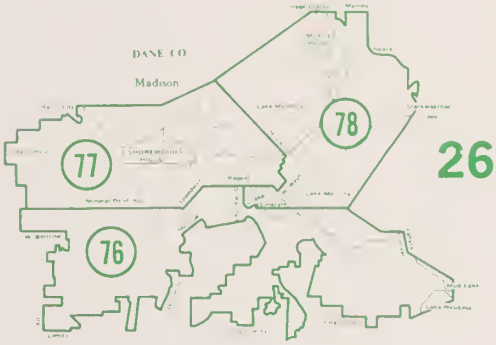


27. Sen. Bidwell
Assembly Districts
79. T. Thompson
80. Giese
81. Cyrak

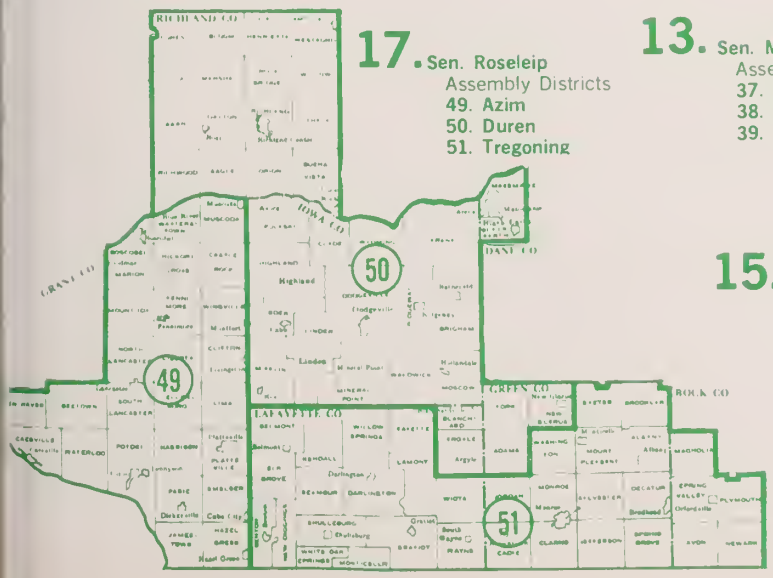




16. Sen. C. Thompson
Assembly Districts
46. O'Malley
47. Mielke
48. Mittness

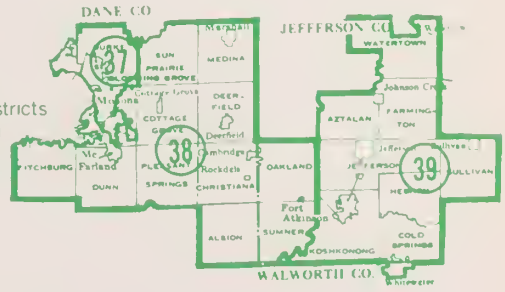


26. Sen. Risser
Assembly Districts
76. Munts
77. Miller
78. Nager

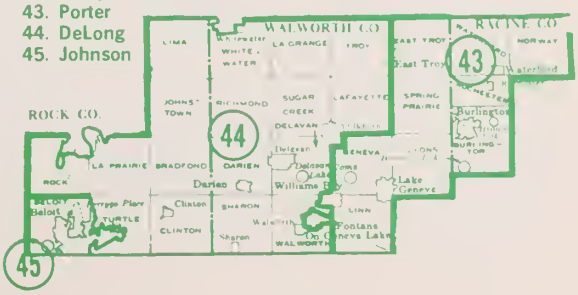


17. Sen. Roseleip
Assembly Districts
49. Azim
50. Duren
51. Tregoning

13. Sen. McKenna
Assembly Districts
37. Anderson
38. Everson
39. Wackett



15. Sen. J. Swan
Assembly Districts
43. Porter
44. DeLong
45. Johnson



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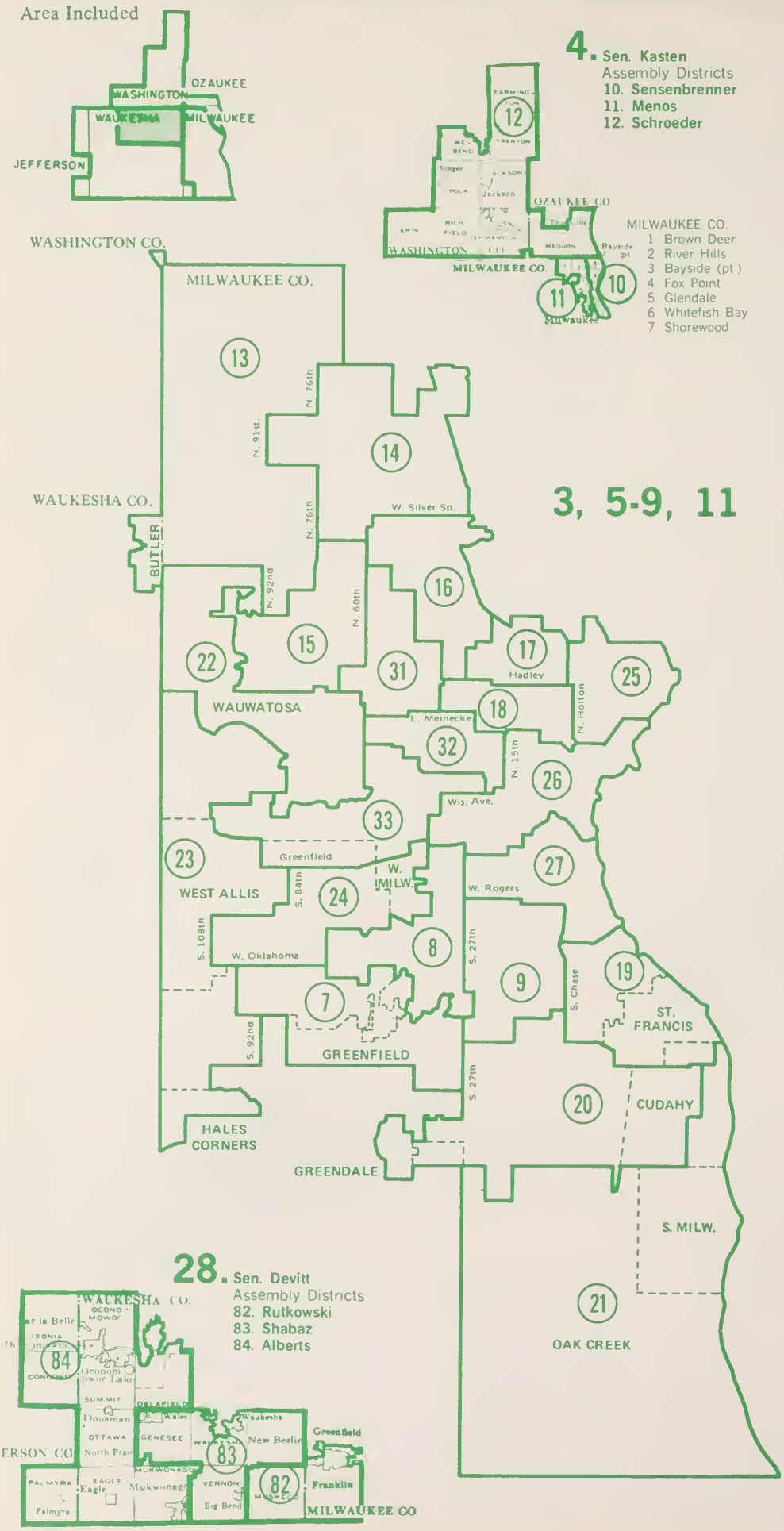

State Officers

State Capitol
Madison, Wisconsin 53702

ernor — Lucey, Patrick J. (D), 1015 Farwell Court, Madison 53704

Governor — Schreiber, Martin J. (D), 3128 N. 50th St., Milwaukee 53216

. of State — Zimmerman, Robert C. (R), 4502 Hammersley Rd., Madison 53711

e Treasurer — Smith, Charles P. (D), 509 S. Spooner St., Madison 53711

rney General — Warren, Robert W. (R), 209 Glacier Dr., Madison 53705

Members of Congress from Wisconsin

SENATORS

Senate Office Bldg.
Washington, D.C. 20510

xmire, William (D), 4613 Buckeye Rd., Madison 53716

son, Gaylord (D), 618 Bordner Drive, Madison 53705

REPRESENTATIVES

House Office Bldg.
Washington, D.C. 20515

Aspin, Les (D), 205 - 15th St., Racine 53403

Kastenmeier, Robert W. (D), 745 Pony Lane, Sun Prairie 53590

Thomson, Vernon W. (R), 578 E. Second St., Richland Center 53581

Zablocki, Clement J. (D), 3245 N. Drury Lane, Milwaukee 53215

Reuss, Henry S. (D), 2545 N. Nahl Ave., Milwaukee 53211

Steiger, William A. (R), 645 Wisconsin St., Oshkosh 54901

Obey, David R. (D), 831 Dunbar St., Wausau 54401

Froehlich, Harold V. (R), 514 N. Drew St., Appleton 54911

Davis, Glenn R. (R), 3790 S. Center Rd., Waukesha 53186

Members of the 1973 Wisconsin Senate

Name (Party)	District	Home Address
Bablitch, William A. (D)	24	1609 Michigan St., Stevens Point 54481
†Bidwell, Everett V (R)	27	612 W Edgewater St, Portage 53901
†Chilsen, Walter John (R)	29	1821 Town Line Rd., Wausau 54401
*Devitt, James C (R)	28	9106 W. Waterford Square, S Greenfield 53228
†Dorman, Henry (D)	21	422 16th St, Racine 53403
Flynn, James T (D)	8	1432 S. 86th St., West Allis 53214
Frank, Kurt A (D)	7	933 E Ohio Ave, Milwaukee 53207
*Hollander, Walter G. (R)	18	R 1, Rosendale 54974
†Johnson, Raymond C. (R)	31	221 N 12th St., Eau Claire 54701
Kasten, Robert W., Jr (R)	4	5901 W Brown Deer Rd, Milwaukee 53223
†Kendziorski, Casimir (D)	3	2027 S. 14th St., Milwaukee 53204
*Keppler, Ernest C. (R)	20	909 New York Ave, Sheboygan 53081
*Knowles, Robert P (R)	10	335 E First St, New Richmond 54017
*Knutson, Milo G. (R)	32	804 Cass St, La Crosse 54601
*Krueger, Clifford W (R)	12	122 N State St., Merrill 54452
*LaFave, Reuben (R)	30	R 1, Box 89-A, Oconto 54153
La Follette, Douglas (D)	22	6510 5th Ave, Kenosha 53140
*Lorge, Gerald D (R)	14	P.O. Box 147, Bear Creek 54922
†Martin, Jerome A (D)	1	Box 6, Whitelaw 54247
†McKenna, Dale T (D)	13	336 E North St, Jefferson 53549
†Murphy, Roger P (R)	33	1012 Hawthorne Circle, Waukesha 53186
†Parys, Ronald G (D)	9	1221 E Clarke St., Milwaukee 53212
†Peloquin, Bruce S. (D)	23	R 5, Chippewa Falls 54729
Petri, Thomas E. (R)	2	R. 3, Fond du Lac 54935
*Risser, Fred A. (D)	26	5409 Esther Beach Rd., Madison 53713
†Roseleip, Gordon W (R)	17	Box 167, Darlington 53530
†Schuele, Wilfred (D)	5	3036 N. 84th St., Milwaukee 53222
†Steinhilber, Jack D. (R)	19	1748 Southland Ave., Oshkosh 54901
†Swan, James D. (R)	15	R. 2, Elkhorn 53121
Swan, Monroe (D)	6	2432 W. Auer Ave., Milwaukee 53206
Theno, Daniel O. (R)	25	R 1, Ashland 54806
*Thompson, Carl W. (D)	16	R. 3, Stoughton 53589
†Whittow, Wayne F. (D)	11	4921 W Washington Blvd., Milwaukee 53208

†Hold-over senators from 1971 legislature.

*Served in 1971 senate.

Members of the 1973 Wisconsin Assembly

Name (Party)	District	Home Address
*Alberts, John M (R)	84	1228 W. Wisconsin Ave., Oconomowoc 53066
*Anderson, Norman C. (D)	37	5325 Marsh Rd., Madison 53704
*Atkinson, William P. (D)	21	1115 16th Ave., South Milwaukee 53172
*Azim, James N., Jr. (R)	49	Muscoda 53573
*Baldus, Alvin (D)	69	111 12th St., Menomonie 54751
*Barbee, Lloyd A (D)	18	321 E. Meinecke Ave., Milwaukee 53212
Barczak, Gary J (D)	24	5728 W Rita Dr, West Allis 53219
Behnke, Robert E (D)	14	4001 W Calumet Rd., Milwaukee 53209
*Berger, David G. (D)	13	4443 N 82nd St., Milwaukee 53218
*Bolle, Everett E (D)	3	Forest Home Dr, Francis Creek 54214
*Bradley, Gordon R. (R)	57	2644 Elo Rd., Oshkosh 54901
Bruhy, Bill B (R)	59	27 Reed, Plymouth 53073
*Byers, Francis R (R)	40	Garfield Avenue, Marion 54950
*Conradt, Ervin W. (R)	41	R 2, Shiocton 54170
*Conta, Dennis (D)	25	3489 N Hackett Ave., Milwaukee 53211
Cyrak, Mel J (R)	81	R 1, Box 133, Marshall 53559
*Czerwinski, Joseph C (D)	27	1607 S. 8th St, Milwaukee 53204
*Day, Laurence J. (D)	86	R 1, Eland 54427
DeLong, Delmer E (R.)	44	R 2, Clinton 53525
Donoghue, Sheehan (R)	35	102 Cottage St., Merrill 54452
*Dorff, Eugene (D)	65	8045 19th Ave., Kenosha 53140
*Dueholm, Harvey L. (D)	28	R 2, Luck 54853
*Duren, Joanne M (D)	50	Cazenovia 53924
*Earl, Anthony S. (D)	85	917 Graves Ave, Wausau 54401
*Early, Michael P (D)	30	1052 S. Fork Dr, River Falls 54022
Elconin, Michael (D)	16	4566 N. 31st St, Milwaukee 53209
*Ellis, Michael G. (R)	55	315½ N Commercial, Neenah 54956
*Everson, Harland E (D)	38	R 3, Box 750, Edgerton 53534
*Ferrall, Michael (D)	62	1816 Wisconsin Ave, Racine 53403
Flintrop, Richard A (D)	56	629 W Irving, Oshkosh 54901
*Giese, Kenyon E (R)	80	328 Dallas St, Sauk City 53583
Gibson, Lawrence R (R)	95	2215 S. 23rd St, La Crosse 54601
Gower, John C (R)	4	312 Terraview Dr, Green Bay 54301
*Groshek, Leonard A. (D)	71	2125 Indiana Ave Stevens Point 54481
*Grover, Herbert J (D)	87	R 2, Shawano 54166
Hauke, Thomas A (D)	23	11040 W Wildwood Lane, West Allis 53227
*Hephner, Gervase A. (D)	6	R 4, Box 287, Chilton 53014
*Jackamonis, Edward G. (D)	98	622 Greenmeadow Dr., Waukesha 53186
*Johnson, Gary K. (D)	45	1818 Fayette St., Beloit 53511
Kedrowski, David R (D)	74	Box 415, Washburn 54891
Keegan, Earl F (D)	8	1317 S 36th St., Milwaukee 53215
Kincaid, Lloyd H (R)	36	110 N Crandon Ave., Crandon 54520
*Kleczka, Gerald D. (D)	9	3427 S 9th Pl, Milwaukee 53215
*Klicka, George H. (R)	22	8442 Kenyon Ave., Wauwatosa 53226
Lallensack, Francis J (D)	2	1812 S 23rd, Manitowoc 54220
Lewis, James R (R)	53	R 3, West Bend 53095
*Lewison, Bernard (R)	96	531 E Hillcrest, Viroqua 54665
*Looby, Joseph L (D)	68	1156 E. Madison St., Eau Claire 54701
*Luckhardt, Esther Doughty (R)	54	211 N. Hubbard St, Horicon 53032
Matty, Richard P (R)	88	Crivitz 54114
*McEssy, Earl F (R)	52	361 Forest Ave., Fond du Lac 54935
*Menos, Gus G. (D)	11	5411 N 19th St., Milwaukee 53209
*Merkel, Kenneth J. (R)	99	3405 N Brookfield Rd., Brookfield 530
*Mielke, Janet Soergel (D)	47	R 1, Milton Junction 53564
*Miller, Marjorie M. (D)	77	1937 Arlington Pl., Madison 53705
*Mittness, Lewis T (D)	48	730 N Ringold St, Janesville 53545
*Mohn, Leo O. (D)	29	Woodville 54028
*Molinaro, George (D)	64	424 44th St., Kenosha 53140
Munts, Mary Lou (D)	76	6102 Hammersley Rd, Madison 53711
Murray, Thomas B. (D)	73	1308 N 13th St., Superior 54880
*Nager, Edward (D)	78	840 Spaight St., Madison 53703
Niebler, John H. (R)	97	W177, N9027 St Stevens Ct., Menomo
*Oberle, Eugene W (D)	91	R 3, Stanley 54768
*Oestreicher, John C (D)	70	911 S Cherry Ave., Marshfield 54449
Olson, Russell A. (R)	66	Bassett 53101
*O'Malley, David D. (D)	46	315 Main St, Waunakee 53597
Opitz, David W (R)	60	R 1, Box 641, Saukville 53080
*Otte, Carl (D)	58	1440 S 22nd St, Sheboygan 53081
*Pabst, Richard E (D)	33	457-A S. 74th St., Milwaukee 53214
Plewa, John R (D)	20	4557 S 23rd St., Milwaukee 53221
Porter, Cloyd A (R)	43	R 3, Box 331, Burlington 53105
*Quackenbush, Robert L (R)	92	510 N Spring, Sparta 54656
*Quinn, Jerome (R)	90	137 N. Oakland Ave, Green Bay 5430
*Roberts, Virgil (D)	94	308 Park Lane, Holmen 54636
*Rogers, William J (D)	5	1800 Peters Rd, Kaukauna 54130
Rohner, Henry (R)	63	4906 S. Green Bay Rd., Racine 53403
Rooney, James F. (D)	61	1500 Michigan Blvd, Racine 53402
Roth, Tobias A (R)	42	417 E Longview Dr, Appleton 54911
*Rutkowski, James A (D)	82	10223 Kay Pkwy, Hales Corners 5313
*Sanasarian, Harout (D)	26	1111 N Astor St., Milwaukee 53202
*Schneider, Marlin D (D)	93	921 Washington St, Wisconsin Rapids 5
*Schricker, Kenneth M (R)	75	R 2 Spooner 54801
*Schroeder, Frederick C (R)	12	R 1, West Bend 53095
*Sensenbrenner, F James, Jr, (R)	10	1601 E Lake Bluff Blvd., Milwaukee 5
*Shabaz, John C (R)	83	21425 W Glengarry Rd New Berlin 5
*Sicula, Paul E (D)	31	3845 N 56th St, Milwaukee 53216
*Sweda, Joseph (D)	34	R 1, Lublin 54447
*Swoboda, Lary J. (D)	1	507 Oak St, Luxemburg 54217
Tesmer, Louise M (D)	19	4252 S. Nicholson Ave, Milwaukee 5320
*Thompson, Tommy G. (R)	79	609 Academy St, Elroy 53929
*Tobiasz, Raymond J (D)	7	3145 S. 50th St, Milwaukee 53219
*Tregoning, Joseph E (R)	51	435 N Judgment St., Shullsburg 53586
Tropman, Peter J (D)	32	1810 W Cherry St, Milwaukee 53205
*Vanderperren, Cletus (D)	89	R 5, Green Bay 54303
*Wackett, Byron F (R)	39	100 Oak Hill Court, Watertown 53094
*Wahner, James W (D)	15	6766 W Appleton Ave, Milwaukee 532
Ward, Walter L, Jr (D)	17	3124 N 13th St Milwaukee 53206
*Wilcox, Jon P (R)	72	R 1, Wautoma 54982
*Willkom, Terry A (D)	67	R 1 Box 20-A, Chippewa Falls 54729

*Served in 1971 assembly.

ERE

Fractures

erever it hurts,
pirin Compound with
eine usually provides
relief needed.

ERE

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eneral, only pain so severe
it requires morphine is
ond the scope of
pirin Compound with Codeine.

prescribing convenience:
up to 5 refills in 6 months,
our discretion (unless
tricted by state law); by
phone order in many states.

pirin Compound with
deine **No. 3,** codeine
sphate* 32.4 mg. (gr. ½);
4, codeine phosphate*
8 mg. (gr. 1).*Warning—
y be habit-forming. Each
let also contains: aspirin
3½, phenacetin gr. 2½,
feine gr. ½.

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Research Triangle Park
North Carolina 27709

WHEREVER IT HURTS

EMPIRIN® COMPOUND c̄ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

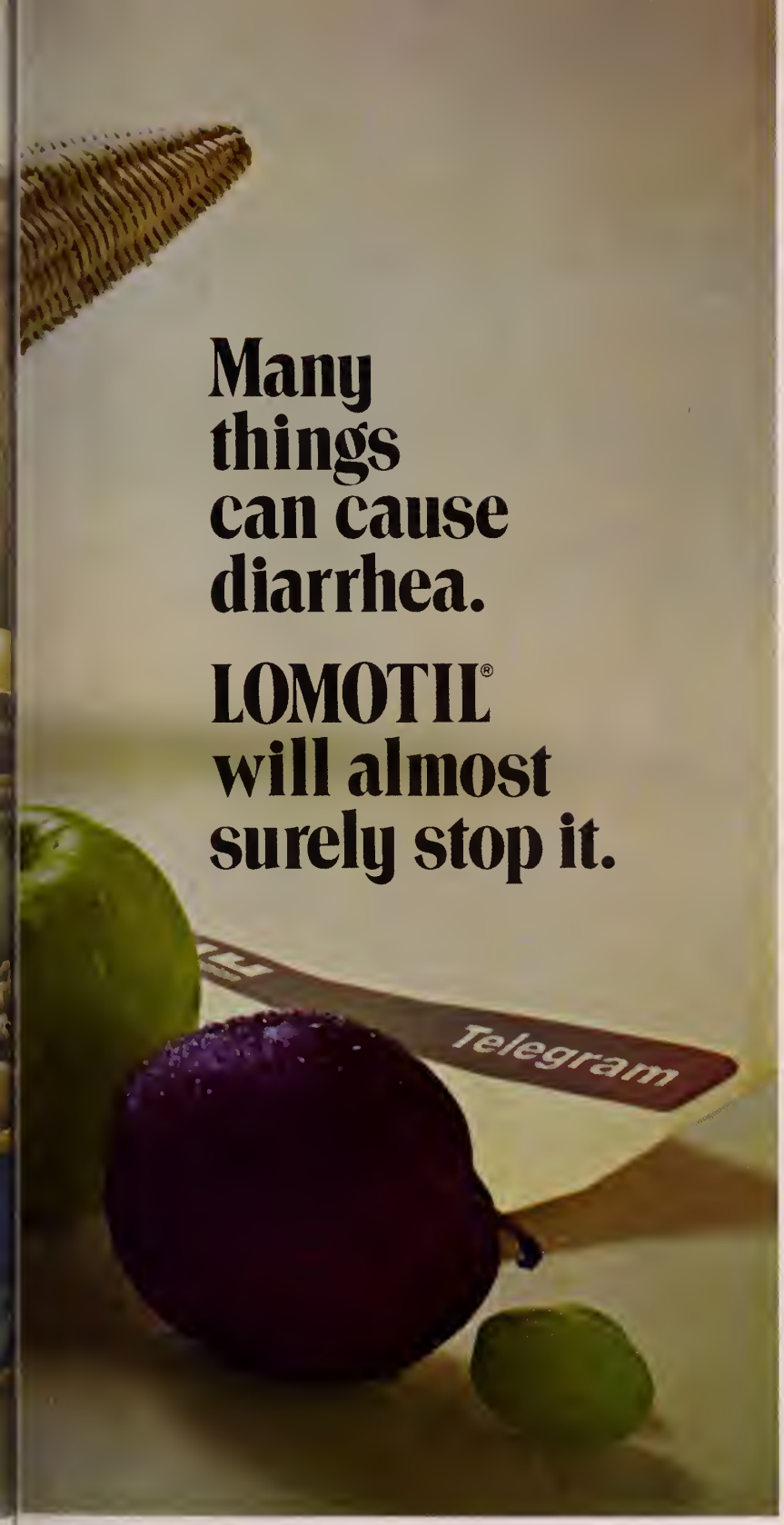
Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphe late HCl is theoretically possible at high dosag not exceed recommended dosages. Administer caution to patients receiving addicting drug known to be addiction prone or having a histo drug abuse. The subtherapeutic amount of atr is added to discourage deliberate overdos strictly observe contraindications, warnings and cautions for atropine; use with caution in chi since signs of atropinism may occur even wit recommended dosage.

Adverse reactions: Atropine effects include dr of skin and mucous membranes, flushing and nary retention. Other side effects with Lomot clude nausea, sedation, vomiting, swelling of gums, abdominal discomfort, respiratory depres numbness of the extremities, headache, dizzi depression, malaise, drowsiness, coma, leth



The causes of diarrhea are as varied as man's complaints and indiscretions. Because the causes of diarrhea can be obscure and because uncontrolled diarrhea can present serious problems, it is important to know a drug that will usually stop diarrhea promptly. For many physicians, the antidiarrheal drug of choice is Lomotil. It provides almost certain control of diarrhea.

It is also useful in controlling the intestinal transit time of patients with ileostomies and colostomies and the diarrhea occurring after gastric surgery.

Serious side effects are infrequent with Lomotil. It should be used with caution in young children, however, because of their variability in response. Use of Lomotil in children under two years of age is contraindicated.

For the almost certain control of diarrhea,

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
Diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: may be habit forming)
Atropine sulfate ..... 0.025 mg.

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Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

ia, restlessness, euphoria, pruritus, angioneu-
dema, giant urticaria and paralytic ileus.
e *and administration:* ***Lomotil is contraindi-
in children less than 2 years old.*** Use only
l liquid for children 2 to 12 years old. For
to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years,
(2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5
daily; adults, two tablets (5 mg.) t.i.d. to two
(5 mg.) q.i.d. or two regular teaspoonfuls (10
mg.) q.i.d. Maintenance dosage may be as
one fourth of the initial dosage. Make down-
osage adjustment as soon as initial symptoms
ntrolled.
osage: Keep the medication out of the reach
dren since accidental overdosage may cause
, even fatal, respiratory depression. Signs of
sage include flushing, lethargy or coma, hypo-
reflexes, nystagmus, pinpoint pupils, tachy-
and respiratory depression which may occur
12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.
Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

MINOCIN® made the difference in just eight days.*

Clinical Data:
Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

Semisynthetic
MINOCIN®
MINOCYCLINE HCl
Capsules, 100 mg: 2 *stat*, 1 q 12 h.

Minocycline is a tetracycline with activity against a wide range of gram-negative and gram-positive organisms.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. Pregnancy: In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class. Safe use has not been established in children under 13.
Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.
Adverse Reactions: (Common to all tetracyclines, including MINOCIN) GI: (with both oral and parenteral use): anorexia, nausea, light-headedness, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
NOTE: *Concomitant therapy:* Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965 436-2

Workmen's Compensation and the Physician

VIRTUALLY EVERY physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury or illness sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or Ralph E. Gintz, Administrator of the Workmen's Compensation Division, Hill Farms State Office Building, Box 2209, Madison, Wis. 53701, if you have any questions.

Four points of advice will aid every physician in dealing with Workmen's Comp.:

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations (formerly the Industrial Commission). Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin.

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or Ralph E. Gintz at the addresses noted above.

WORKMEN'S COMPENSATION RULES

A physician or any other employer except a farmer is subject to the Workmen's Compensation Act if (1) he usually employs three or more employes or (2) he pays wages of $500 or more in any calendar quarter subsequent to July 1, 1968, covering services within Wisconsin.

An employer subject to the Act must have Workmen's Compensation insurance coverage, which can be obtained from any insurance company authorized to do such business within Wisconsin.

Serious penalties exist for failure to have insurance coverage. First, such failure is a misdemeanor and subject to fine of from $10 to $100 for each day of such illegal operation.

Second, the employer is personally responsible if one of the employes is injured while he is subject to coverage and is uninsured. Negligence by the employe is not a defense, and it need not be shown that the injury was caused by negligence of the employer.

A physician paying such wages need only obtain an insurance policy for Workmen's Compensation to comply with the law. The state Workmen's Compensation office is automatically notified of the issuance of the policy.

IMPLIED CONSENT OF OPERATOR OF MOTOR VEHICLE

Any person operating a motor vehicle on the highways of the State of Wisconsin is deemed to have given consent to a test of his blood, breath, or urine to determine the alcohol content of his blood.

This law comes into operation only if the person is arrested and cited for driving under the influence of an intoxicant.

Refusal to submit to a test for blood alcohol under implied consent may lead to suspension of one's driver's license or a mandatory two-day imprisonment if convicted.

Under the law, only a physician or one acting under the direction of a physician may withdraw blood for the blood test, if used. The law provides immunity from liability, except for negligence, for persons drawing blood for implied consent testing.

The State Medical Society of Wisconsin has prepared guidelines for physicians in connection with their responsibilities under the implied consent law. These guidelines and a copy of the consent form may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701, or telephone 608/257–6781. (Single copies: 25¢ with order)

REFER CHILD PLACEMENT CASES TO THESE LICENSED AND PUBLIC AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson Street, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Jewish Family & Children's Service, The Plankinton Bldg., Suite 3185, 161 W. Wisconsin Avenue, Milwaukee 53203.

Methodist Children's Services of Wisconsin, 303 Price Place, Lincoln Bldg., Madison 53711.

PUBLIC AGENCIES:

*Division of Family Services (See page 84 for list of Regional Offices).

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

* Nondenominational.

LICENSED MATERNITY HOMES

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19305 West North Ave., Brookfield 53005.

St. Francis Maternity Residence, 11th and Market Streets, La Crosse 54601.

Marian Hall, 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

ADOPTION

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. □

Clinical Center Study of Patients with Primary or Secondary Amenorrhea, or Oligomenorrhea

The cooperation of physicians is requested in the referral of patients with primary or secondary amenorrhea, or oligomenorrhea for studies being conducted by the National Institute of Child Health and Human Development's Reproduction Research Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Selected patients in the following categories will be admitted for diagnosis, treatment, or both:

1. Primary or secondary amenorrhea. Ovulation induction will be done in appropriate patients interested in conceiving.
2. Oligomenorrhea with intermenstrual intervals of 35–45 days. Anovulatory or infertile patients referred for ovulation induction in this category should have undergone appropriate studies to rule out organic pelvic disease.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: JUDITH VAITUKAITIS, MD or GRIFF T. ROSS, MD, Clinical Center, Room 10-B-09, National Institutes of Health, Bethesda, Md. 20014. Telephone: 301/496–4686 or 301/496–6974. □

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes require that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful.

Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of this issue.

17. Drug addiction?

No.

18. Abused children?

Yes. See article in January 1970 "Blue Book" issue of WISCONSIN MEDICAL JOURNAL at page 25.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1973, you must pay the final installment of the estimated federal and Wisconsin tax on your 1972 income. This may necessitate an amended declaration by that date if you find that you underestimated 1972 income. A final income tax return for 1972, filed on or before January 31, 1973, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1972 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1972.
   (3) File fourth quarterly return for 1972 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1973, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Department of Industry, Labor and Human Relations.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1973 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1973. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1973. As to the final installment due in January, 1974, read the procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of four exception provisions following. (1) You pay an amount at least equal to the tax shown on your return for the preceding taxable year. This exception had been superseded during the period the Federal ten percent surcharge existed. Since repeal, this exception now exists again. (2) You may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (3) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (4) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

   The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

   Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary, Medical Examining Board, Department of Regulation & Licensing, State of Wisconsin, 110 No. Henry Street, Madison, Wis. 53703, in the month of January. This registration will be on a form furnished by the Medical Examining Board and should be accompanied by the registration fee shown on that form. Sec. 448.07, Wis. Statutes.

ANNUAL NARCOTICS AND DANGEROUS DRUGS REGISTRATION

All physicians are required to have a Bureau of Narcotics and Dangerous Drugs number (BNDD no.). The Regional Office of the Bureau in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee. If you move, or change your place or places of business, you must notify the Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604.

COMMITMENT REGISTRATION

Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.

HELPFUL INFORMATION FOR HOSPITAL MEDICAL STAFFS

ACCREDITATION MANUAL FOR HOSPITALS

Published by the Joint Commission on Accreditation of Hospitals (JCAH) in 1971, the manual is available as a loose-leaf binder edition for $8.00 (includes updating service through 12–31–72); or a soft-cover edition for $2.25. Explains the new JCAH STANDARDS for hospitals that became effective July 1, 1971. Special attention is given to emergency departments and the way that patients are handled. Although the new STANDARDS do not require all hospitals to have an emergency department, they must have a well-defined plan for emergency care based on community need and hospital capability. STANDARDS give minimum policies and procedures for both hospitals and medical staffs. Mandatory medical records on all emergency patients must be reviewed regularly to evaluate the quality of care provided in the emergency department. For copies: Write to JCAH, 645 North Michigan Ave., Chicago, Ill. 60611.

NARCOTICS

Annual Registration

All physicians are required to have a Bureau of Narcotics and Dangerous Drugs number (BNDD no.). The Regional Office of the Bureau in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee.

Change of Residence

If you move, or change your place or places of business, you must notify the Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604.

In Case of Death

The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's unused government order forms and narcotic drugs should be disposed of as soon as possible. Unused government order forms (Form 2513) should be returned to the Regional Director, Federal Bureau of Naroctics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director in Chicago, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the drugs. No remuneration will be made for the drugs surrendered to the Bureau of Narcotics and Dangerous Drugs."

Preprinted Prescription Blanks

The Justice Department, Federal Bureau of Narcotics and Dangerous Drugs, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

THE HIPPOCRATIC OATH is reproduced below for the convenience of physicians and others who may have need of it from time to time.

THE OATH OF HIPPOCRATES

I SWEAR BY APOLLO, THE PHYSICIAN, AND AESCULAPIUS AND HEALTH AND ALL-HEAL AND ALL THE GODS AND GODDESSES THAT, ACCORDING TO MY ABILITY AND JUDGMENT, I WILL KEEP THIS OATH AND STIPULATION:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary art of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times; but should I trespass and violate this oath, may the reverse be my lot.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by ss. 200.26 and 204.31 (3m) and by no other law relating to insurance unless such law is referred to in ss. 200.26 and 204.31 (3m) and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET • MADISON WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the *Wisconsin Medical Journal*, the Society's Blue Shield plan—Wisconsin Physicians Service / WPS, general administrative offices, dining room, meeting room, and Council room. Nearly 300 committee and other meetings are held here annually.

SERVICES TO MEMBERS

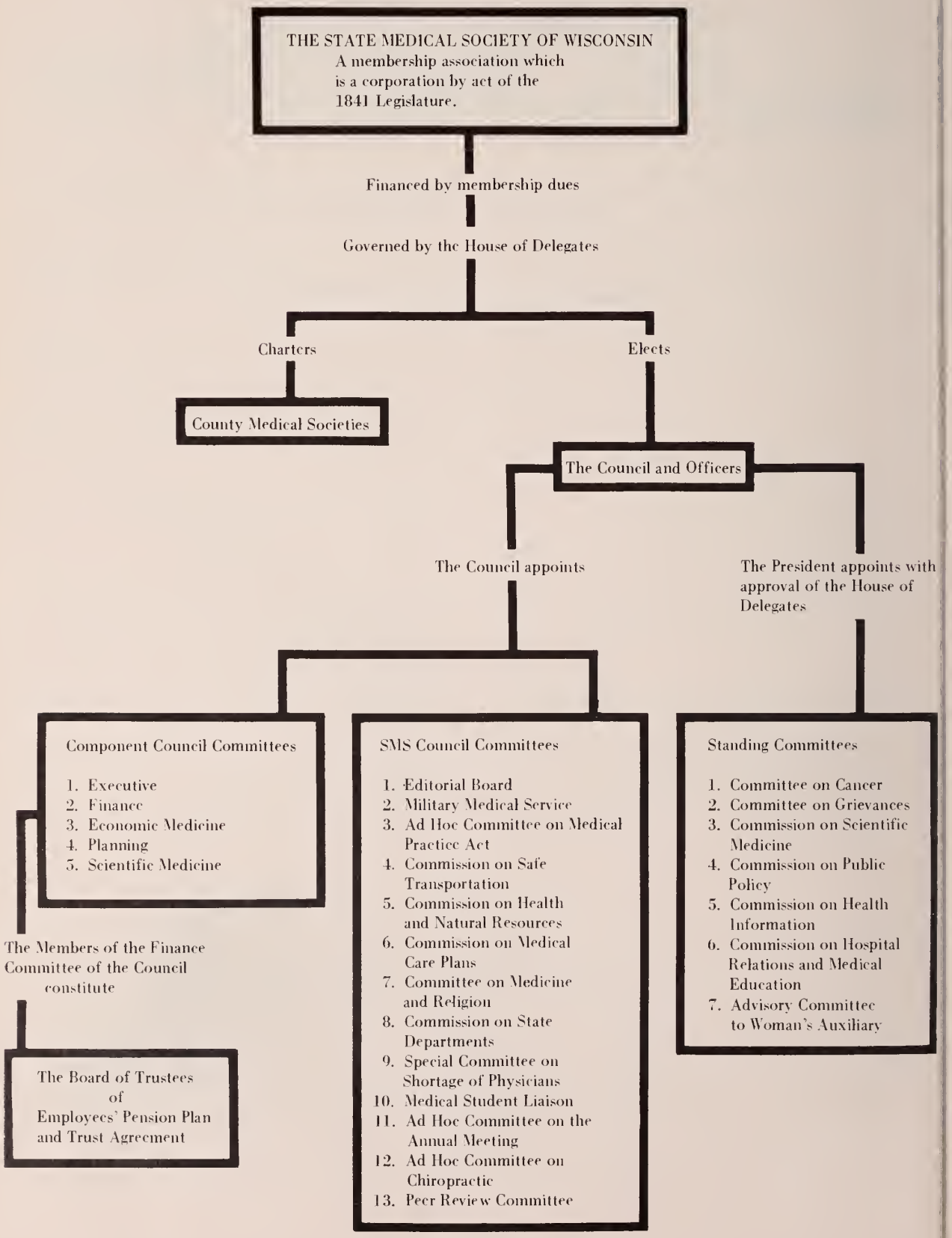
- Health Educational Activities
- Film Service
- Health Careers Information
- Speakers Service
- Voluntary Health Agency Contacts
- Student Loans
- Grievance Services
- Museum of Medical Progress and Stovall Hall of Health
- Executive Office Services
- *Wisconsin Medical Journal*
- Life Insurance
- Disability Income Protection
- Wisconsin Work Week of Health
- Business Overhead Insurance
- WPS–Blue Shield Protection
- Open Panel Program under Workmen's Compensation
- Continuing Medical Education Programs
- Physician Placement Services
- Medicolegal Consultation
- Professional Liability Consultation
- Public Relations
- Legislative Representation
- Governmental Agency Contacts
- Medical Economic Advice

THE ANNUAL "BLUE BOOK" ISSUE

SINCE 1924 the Wisconsin Medical Journal has published each January a "Blue Book" edition containing a variety of articles relating to medicolegal, socio-economic matters of direct concern to the physician in his relationship to patients, hospitals, governmental agencies, and others on the "health team." It is unique among medical journals of the United States. In addition to Society membership, it is distributed gratis to senior and junior medical students of the two Wisconsin medical schools, state legislators, clinic managers, and is available to others.

The "Blue Book" is a useful reference book throughout the year. Physicians are urged to keep the Journal handy at all times.

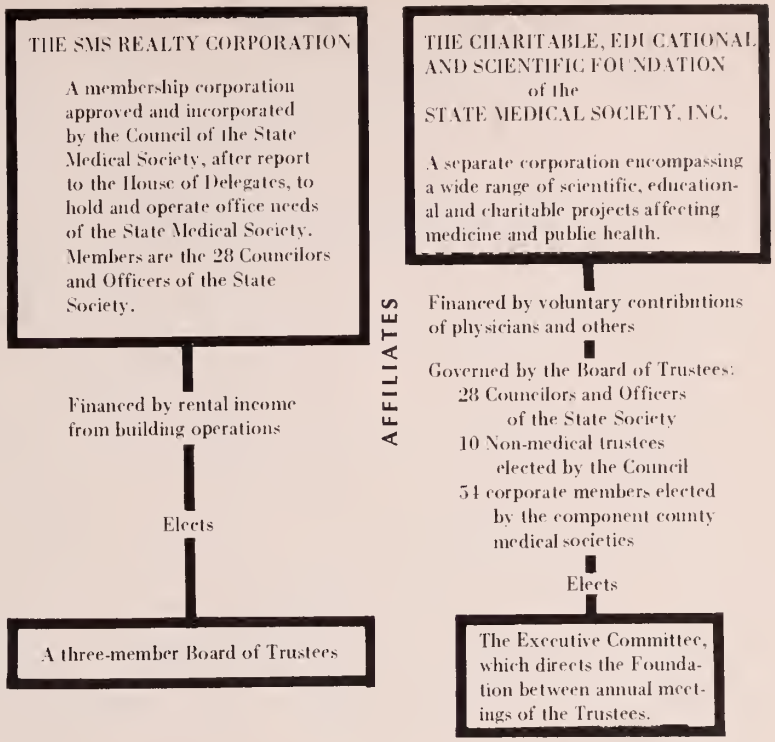
State Medical Society Organization Reflects Democratic Process



THE State Medical Society of Wisconsin belongs to its members: The physicians of Wisconsin; it is theirs to direct, to use, and to serve. To benefit fully from his or her membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

HOW THE **State Medical Society of Wisconsin** SERVES

This is the first in a series of articles explaining State Medical Society organization and activities.



LIKE ALL OTHER VITAL organizations in our society, the State Medical Society of Wisconsin has grown in numbers and in scope since its founding. Today it is a multi-faceted organization with over 4,400 members. When it was created in 1841, seven years before Wisconsin became a state, it included only 13 physicians who had banded together to meet the most elemental needs of frontier medicine.

Following Wisconsin statehood came the development of county medical societies, today the portal of entry to the State Society. There are 54 county and multi-county societies and these directly participate in the governing of the State Society. Each county society elects delegates to the State Society's House of Delegates—one delegate for each 40 dues-paying members. And the House also has representation from 18 scientific sections, or medical specialties, with one delegate from each section. In turn, State Society delegates elect Wisconsin representatives to the national medical organization, the American Medical Association. Here, there is one delegate or alternate for each 1,000 members or part thereof. Thus, a physician's vote in his county society or scientific section is the first step toward an effective voice in state and national medical policies.

The House of Delegates functions as a legislative or policy-making body and generally meets only once a year. At these annual meetings, it elects officers and a Council which is the Society's board of directors. Until the next annual delegates' meeting, full power and authority rests in the Council, consisting of the 21 councilors, the Society's president, president-elect, past president, speaker and vice-speaker of the House of Delegates, treasurer, and secretary. Each of the councilors serves one of the 13 medical districts into which the state is divided.

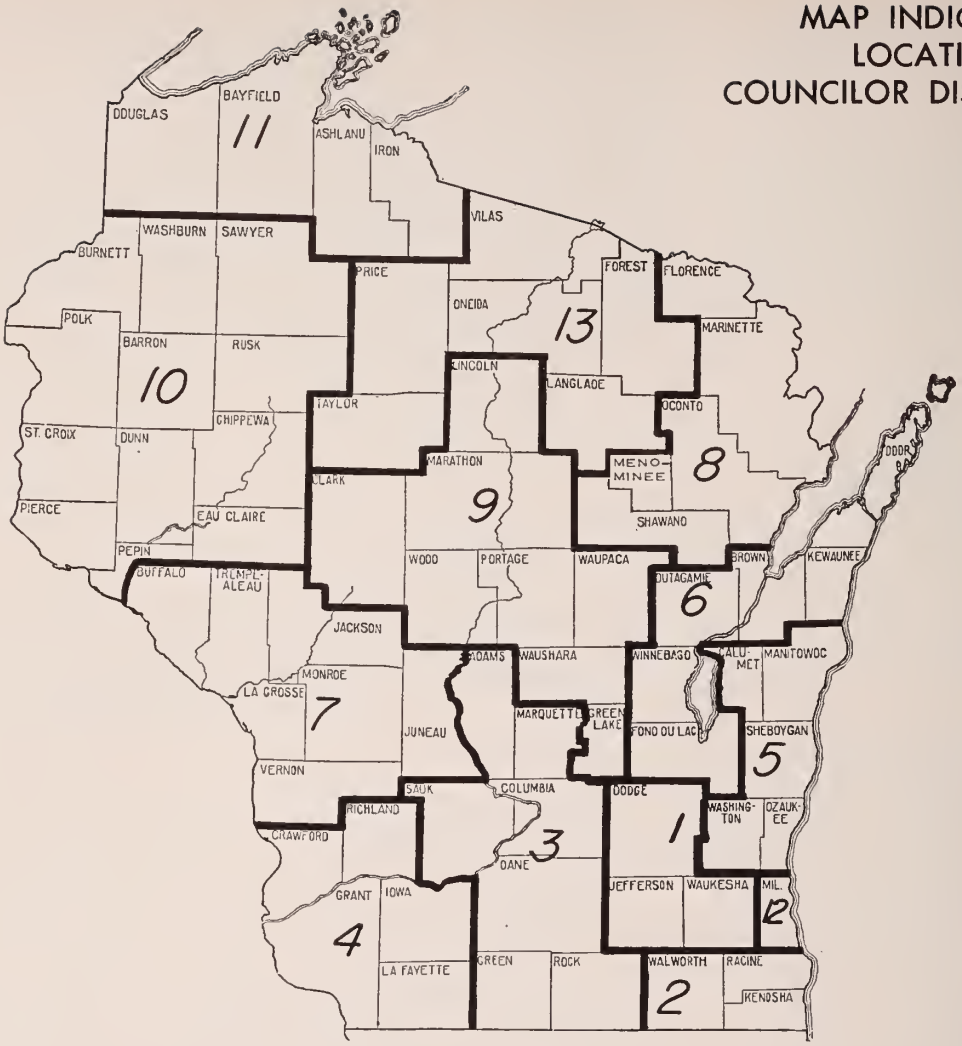
The Council meets quarterly, unless called into special session. To cope with its large volume of work, Council members are assigned to committees on scientific medicine, economic medicine, planning, and finance. Heads of these committees plus State Society officers form the Executive Committee, which meets monthly. In addition, commissions and committees are appointed in the following areas: liaison with state departments, safe transportation, medical care plans, peer review, *Wisconsin Medical Journal* editorial board, medicine and religion, health and natural resources, military medical service, and medical student liaison.

Serving as the real head of Wisconsin physicians is the president of the State Medical Society. He also appoints a number of committees and commissions, subject to confirmation by the House of Delegates. These groups include public policy, grievances, cancer, scientific medicine, hospital relations and medical education, health information, and Woman's Auxiliary advisory.

The day-to-day affairs of the Society are supervised and coordinated by the secretary, who is elected by the Council. He oversees all the various operations within the State Medical Society, including such diverse areas as legislative liaison, the Society's annual meeting, and the monthly Society publication, *Wisconsin Medical Journal.*

The State Medical Society is a nonprofit, public service organization. Its basic means of financing is through membership dues. Some activities generate all or part of their own support, such as *Wisconsin Medical Journal* (through sale of advertising and subscriptions), and the annual House of Delegates meeting (through sale of exhibit space and luncheon reservations). The Society's annual financial statement can be found in the *Wisconsin Medical Journal* issue immediately following the Annual Meeting. □

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities, and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257–6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis. 53701.

Officers and Councilors 1972-1973

State Medical Society of Wisconsin

OFFICERS OF THE SOCIETY

PRESIDENT (1972–1973) .....**R. F. Purtell, MD**
758 North 27th St., Milwaukee 53208

PRESIDENT-ELECT (1972–1973) .....**G. J. Derus, MD**
5001 Monona Drive, Madison 53716

SECRETARY .....**E. R. Thayer**
330 East Lakeside St., Madison 53701

TREASURER (1972–1973) .....**F. L. Weston, MD**
166 Lakewood Blvd., Madison 53704

SPEAKER (1971–1973) .....**T. J. Nereim, MD**
P.O. Box 65, Mt. Horeb 53572

VICE-SPEAKER (1972–1973) .....**W. D. Hamlin, MD**
Mineral Point 53565

PAST PRESIDENT (1972–1973) .....**G. A. Behnke, MD**
1015 West Wisconsin Ave., Kaukauna 54130

THE COUNCIL

E. J. Nordby, MD, Madison, Chairman

J. E. Dettmann, MD, Green Bay, Vice-chairman

COUNCILORS AND DISTRICTS*

First: Dodge, Jefferson, and Waukesha County Societies. **J. J. Foley, MD** (1972–1975), P.O. Box 427, Menomonee Falls 53051.

Second: Kenosha, Racine, and Walworth County Societies. **Louis Olsman, MD** (1972–1975), 2108 63rd St., Kenosha 53140.

Third: Dane, Columbia–Marquette–Adams, Green, Rock, and Sauk County Societies. **E. J. Nordby, MD** (1970–1973), 2704 Marshall Ct., Madison 53705; **M. F. Huth, MD** (1971–1974), 203 Fourth St., Baraboo; **R. L. Beilman, MD** (1972–1975), 1313 Fish Hatchery Rd., Madison 53715.

Fourth: Crawford, Grant, Iowa, Lafayette, and Richland County Societies. **R. W. Edwards, MD** (1970–1973), 1313 W. Seminary St., Richland Center 53581.

Fifth: Calumet, Manitowoc, Sheboygan, Washington, and Ozaukee County Societies. **W. F. Smejkal, MD** (1970–1973), 601 Reed Ave., Manitowoc 54220.

Sixth: Brown, Door–Kewaunee, Fond du Lac, Outagamie, and Winnebago County Societies. **Howard Mauthe, MD** (1970–1973), 3802 DeNeveu Lane, Fond du Lac 54935; **J. E. Dettmann, MD** (1971–1974), 1751 Deckner Ave., Green Bay 53401.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo, and Vernon County Societies. **E. P. Rohde, MD** (1971–1974), Galesville 54630.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. **R. D. Heinen, MD** (1971–1974), 134 N. Main St., Oconto Falls 54154.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca, and Wood County Societies. **R. F. Lewis, MD** (1971–1974), 650 S. Central Ave., Marshfield 54449.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, and Rusk County Societies. **W. R. Manz, MD** (1971–1974), 204 East Grand Ave., Eau Claire 54701.

Eleventh: Ashland–Bayfield–Iron, and Douglas County Societies. **T. J. Doyle, MD** (1972–1975), 1507 Tower Ave., Superior 54880.

Twelfth: The Medical Society of Milwaukee County. **T. J. Foley, MD** (1972–1975), 3316 West Wisconsin Ave., Milwaukee 53208; **D. K. Schmidt, MD** (1972–1975), 330 W. Silver Spring Drive, Milwaukee 53217; **W. J. Egan, MD** (1970–1973), 525 East Wells St., Milwaukee 53202; **DeLore Williams, MD** (1971–1974), 8501 W. Lincoln Ave., West Allis 53227; **R. B. Pittelkow, MD** (1971–1974), 111 E. Wisconsin Ave., Milwaukee 53202; **P. G. LaBissoniere, MD** (1971–1973), 10425 W. North St., Wauwatosa 53226.

Thirteenth: Forest, Langlade, Oneida–Vilas, and Price–Taylor County Societies. **W. W. Meyer, MD** (1971–1974), 101 W. Gibson Ave., Medford 54451.

Past President Behnke

President Purtell

Speaker Nereim

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

W. B. Hildebrand, MD (1972–1973), 59 Racine St., Menasha 54952.

R. E. Galasinski, MD (1972–1973), 3333 South 27th St., Milwaukee 53215.

J. M. Bell, MD (1973–1974), 2500 Hall Ave., Marinette 54143.

G. E. Collentine, Jr., MD (1973–1974), 2388 N. Lake Drive, Milwaukee 53211.

C. J. Picard, MD (1973–1974), 425 Twenty-first Ave., East, Superior 54880.

Alternates

W. T. Russell, MD (1972–1973), 114 Columbus St., Sun Prairie 53590.

H. F. Twelmeyer, MD (1972–1973), 2500 N. Mayfair Rd., Wauwatosa 53226.

E. M. Dessloch, MD (1973–1974), Box 89, Prairie du Chien 53821.

D. J. Carlson, MD (1973–1974), 2320 North Lake Dr., Milwaukee 53211.

H. J. Kief, MD (1973–1974), 505 East Division St., Fond du Lac 54935.

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* Map indicating location of districts, page 52.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting (March 1973). Dates in parentheses indicate beginning and expiration of term of office.

OFFICERS and COUNCILORS

STATE MEDICAL SOCIETY OF WISCONSIN

R. F. Purtell, MD
President
1973

G. J. Derus, MD
President-elect
1973

G. A. Behnke, MD
Post President
1973

E. J. Nordby, MD
Choirman
1973
Councilor, 3rd Dist.
1973

J. E. Dettmann, MD
Vice-choirman
1973
Councilor, 6th Dist.
1974

T. J. Nereim, MD
Speaker
1973

W. D. Hamlin, MD
Vice-speaker
1973

F. L. Weston, MD
Treasurer
1973

E. R. Thoyer
Secretary

J. J. Foley, MD
Councilor, 1st Dist.
1975

Louis Olsman, MD
Councilor, 2nd Dist.
1975

M. F. Huth, MD
Councilor, 3rd Dist.
1974

R. L. Beilman, MD
Councilor, 3rd Dist.
1975

R. W. Edwards, MD
Councilor, 4th Dist.
1973

W. F. Smejkal, MD
Councilor, 5th Dist.
1973

Howard Mauthe, MD
Councilor, 6th Dist.
1973

E. P. Rohde, MD
Councilor, 7th Dist.
1974

R. D. Heinen, MD
Councilor, 8th Dist.
1974

R. F. Lewis, MD
Councilor, 9th Dist.
1974

W. R. Manz, MD
Councilor, 10th Dist.
1974

T. J. Doyle, MD
Councilor, 11th Dist.
1975

W. J. Egan, MD
Councilor, 12th Dist.
1973

P. G. LaBissoniere, MD
Councilor, 12th Dist.
1973

DeLore Williams, MD
Councilor, 12th Dist.
1974

T. J. Foley, MD
Councilor, 12th Dist.
1975

R. B. Pittelkow, MD
Councilor, 12th Dist.
1974

D. K. Schmidt, MD
Councilor, 12th Dist.
1975

W. W. Meyer, MD
Councilor, 13th Dist.
1974

Standing Committees—1972-1973

State Medical Society of Wisconsin

COMMISSION ON PUBLIC POLICY

W. T. Russell, MD
Chairman

W. T. Russell, MD (1971–1976) ..... Sun Prairie 53590
Chairman 114 Columbus St.

T. P. Belson, MD (1972–1977) ..... Waukesha 53186
1111 Delafield Ave.

T. C. Fox, MD (1972–1977) ..... Antigo 54409
213 Fifth Ave.

M. L. Janssen, MD (1972–1977) ..... Friendship 53934
P. O. Box 10

J. M. Lubitz, MD (1969–1974) .... Oconomowoc 53066
2828 Interlaken Dr., North

P. J. Bates, MD (1972–1973) ..... Eau Claire 54701
515 E. Barstow

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LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Public Information Office, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Guide to the Service Corporation Law**
- **A Guide for Physicians, Hospitals, and News Media**—A discussion of news relationships between physicians, hospitals, newspapers, and radio and television stations. It includes information concerning patients, physicians, and county medical society news, health educational efforts, and advice on the use of the title "Doctor."
- **Guide to Interpretation of Chapter 484, Laws of Wisconsin: 1959**—Relating to fee splitting between physicians and others.
- **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
- **Hearing Conservation Programs for Wisconsin Industries**
- **Health Careers in Wisconsin Chart**
- **Inspection of Medical Records**—An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.
- **School Vision Screening Program**
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- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Single copy 25¢ with order.)
- **Proceedings of Track and Field Institute**—Held at University of Wisconsin, Madison, June 29–30, 1966. (Single copy $5.00 with order.)
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A reprinting of the Constitution and Bylaws will be made in the April 1973 issue, following the House of Delegates' annual session in March 1973.

COUNTY MEDICAL SOCIETIES

Presidents and Secretaries

County Medical Society: President and Secretary, respectively

ASHLAND-BAYFIELD-IRON: John E Kreher, 522 2nd St W, Ashland 54806; Harry H Larson, 320 Superior Ave, Washburn 54891

BARRON-WASHBURN-SAWYER-BURNETT: Harold O Jirsa, Cumberland 54829; Donald E Riemer, Cumberland 54829

BROWN: Frederick G Sehring, 1551 Dousman St, Green Bay 54303; Loren E Hart, 414 E Walnut St, Green Bay 54305; (Treasurer: J T McManus, 2925 Waubenoor Dr, Green Bay 54301)

CALUMET: James W Knauf, 36 E Main, Chilton 53014; J C Pinney, 507C W Main St, Hilbert 54129

CHIPPEWA: C R Gonzaga, 133 W Central, Chippewa Falls 54729; Reynaldo C Maniquiz, 600 Bay St, Chippewa Falls 54729

CLARK: Nazario R Capati, 216 Sunset Place, Neillsville 54456; Ana C Capati, 305 Sunset Place, Neillsville 54456

COLUMBIA-MARQUETTE-ADAMS: Celso A Villavicencio, 108 E Cook St, Portage 53901; Modesto M Ferrer, PO Box 308, Rio 53960

CRAWFORD: Thomas F Farrell, 610 E Taylor St, Prairie du Chien 53821; Michael S Garrity, 610 E Taylor St, Prairie du Chien 53821

DANE: Laurence G Crocker, 20 S Park St, Madison 53715; Louis W Chosy, 1300 University Ave, Madison 53706

DODGE: Alan A Ehrhardt, 130 Warren St, Beaver Dam 53916; Stanley G Cupery, 1200 N Center St, Beaver Dam 53916

DOOR-KEWAUNEE: John J Beck, 1715 Rhode Island St, Sturgeon Bay 54235; Andrew S Lanier, 1218 Ellis St, Kewaunee 54216

DOUGLAS: John A Knights, 3500 Tower Ave, Superior 54880; Edward G Stack, Jr, 1225 Tower Ave, Superior 54880

EAU CLAIRE-DUNN-PEPIN: Harry E Thimke, 3746 Patton St, Eau Claire 54701; Verne A Sperry, 715 S Barstow, Eau Claire 54701

FOND DU LAC: Leslie E Jones, 430 E Division, Fond du Lac 54935; Joseph C Devine, 105 Sheboygan Ave, Fond du Lac 54935; (Treasurer: E Howard Theis, 92 E Division St, Fond du Lac 54935)

FORESTT: E F Castaldo, Laona 54541; D V Moffet, Crandon 54520

GRANT: Charles W Young, 1370 N Water, Platteville 53818; H W Carey, 257 Madison St, Lancaster 53813

GREEN: John R Fuller, 2243 6th St, Monroe 53566; M M Qureshi, 1515 10th St, Monroe 53566

GREEN LAKE-WAUSHARA: J C Koch, 209 E Park Ave, Berlin 54923; Alonzo R Gimenez, 270 E Marquette, Berlin 54923

IOWA: Eduardo DeLafuente, Hollandale 53544; H P Breier, 207 Main St, Montfort 53569

JEFFERSON: John S Garman, 144 W Madison St, Waterloo 53594; David T Quanbeck, 123 Hospital Drive, Watertown 53094

JUNEAU: Jack Strong, 143 Division, Mauston 53948; Clayton Weston, 116 S Adams, New Lisbon 53950

KENOSHA: Louis Olsman, 210B 63rd St, Kenosha 53140; G S Wadina, 6530 Sheridan Road, Kenosha 53140; (Executive Secretary: Mr. Mark J Gorman, 3916 67th St, Kenosha 53140)

LA CROSSE: A Erik Gundersen, 1B36 South St, La Crosse 54601; Charles E. Link, 212 S 11th St, La Crosse 54601

LAFAYETTE: Lyle L Olson, 517 Park Place, Darlington 53530; D F Ruf, 517 Park Place, Darlington 53530

LANGLADE: James O Moermond, 120 W Wilson, Antigo 54409; Donald V Blink, 837 Clermont, Antigo 54409

LINCOLN: J D Millenbah, 716 E 2nd St, Merrill 54452; T O Vechinski, Holy Cross Hospital, Merrill 54452

MANITOWOC: Gilbert H Stannard, 1425 Gunnell Lane, Manitowoc 54220; J R Larsen, 300 E Reed St, Manitowoc 54220

MARATHON: Wolfram G Locher, PO Box 304, Wausau 54401; D K Aughenbaugh, 400 E Thomas St, Wausau 54401

MARINETTE-FLORENCE: John W Boren, Jr, 1510 Main St, Marinette 54143; K G Pinegar, 2500 Hall Ave, Marinette 54143

MILWAUKEE: David J Carlson, 2320 N Lake Drive, Milwaukee 53211; Barney B Becker, 2500 W Lincoln Ave, Milwaukee 53215; (Executive Director: Mr M McManus, 756 N Milwaukee, Milwaukee 53202)

MONROE: Jack D Brown, 202 South K, Sparta 54656; E O Lukasek, 110 E Franklin, Sparta 54656

OCONTO: J K Theisen, 24B N Main St, Oconto Falls 54150; J R Culver, 150 N Main St, Oconto Falls 54154

ONEIDA-VILAS: Henry S Ashe, PO Box 308, Minocqua 54548; L D Eggman, 1020 Kabel Ave, Rhinelander 54501

OUTAGAMIE: Ralph O Kennedy, 604 N Richmond, Appleton 54911; Jesus T Querol, 436 E Longview Drive, Appleton 54911

OZAUKEE: John F Walsh, 100 W Monroe, Port Washington 53074; George F Savage, 125 N Franklin, Port Washington 53074

PIERCE-ST CROIX: J L Craig, West 8th St, New Richmond 54017; Paul S Haskins, 409 Spruce, River Falls 54022

POLK: L O Simenstad, 141 N Cascade, Osceola 54020; Lloyd L Olson, St Croix Falls 54024

PORTAGE: Francesco Sciarrone, 900 Illinois, Stevens Point 54481; J R Sevenich, 1364 College Ave, Stevens Point 54481

PRICE-TAYLOR: J L Murphy, 500 Birch St, Park Falls 54552; Josef Enzinger, S Hwy 13, Park Falls 54552

RACINE: Ernest L MacVicar, Jr, 500 Walton Ave, Racine 53402; T W Dorman, 2908 Taylor Ave, Racine 53402; (Treasurer: Myron Schuster, 717 15th St, Racine 53403; Executive Secretary: G J Berthelsen, PO Box 585, Racine 53403)

RICHLAND: Jack I Spear, 1313 W Seminary, Richland Center 53581; L M Pippin, 1313 W Seminary, Richland Center 53581

ROCK: Ronald P Karzel, 2020 E Milwaukee, Janesville 53545; Donald Knepel, 1344 Creston Park Drive, Janesville 53545

RUSK: William E Raduege, Bruce 54819; Maurice L Whalen, Bruce 54819

SAUK: Donald W Vangor, 703 14th St, Baraboo 53913; Victor G Vergara, Jr, 442 2nd St, Reedsburg 53959

SHAWANO: William A Coan, 610 W Green Bay, Shawano 54166; A J Sebesta, PO Box 311, Shawano 54166

SHEBOYGAN: James S Jensen, Cedar Grove 53013; Robert A Keller, 1011 N Bth St, Sheboygan 53081

TREMPEALEAU-JACKSON-BUFFALO: Rizalino N Yray, PO Box 106, Arcadia 54612; Eugene Krohn, 610 W Adams, Black River Falls 54615

VERNON: P T Bland, 100 Melby St, Westby 54667; DeVerne W Vig, 125 W Jefferson, Viroqua 54665

WALWORTH: Irwin J Bruhn, Walworth 53184; Henry R Mol, 100 S Washington St, Elkhorn 53121

WASHINGTON: Floyd E Morbeck, PO Box 178, West Bend 53095; R F Sorensen, PO Box 178, West Bend 53095

WAUKESHA: A J Motzel, 1111 Delafield, Waukesha 53186; K J Dempsey, N88 W16624 Appleton Ave, Menomonee Falls 53051; (Treasurer: W J Clothier, Jr, 1149 Downing Drive, Waukesha 53186; Executive Secretary: Mr Robert Herzog, 2825 N Mayfair Road, Milwaukee 53222)

WAUPACA: Luis L Galang, PO Box 282, New London 54961; Jerry R Salan, 105 Jefferson St, Waupaca 54981

WINNEBAGO: Gordon H Hardie, 111 E North Water St, Neenah 54956; R W Roberts, 400 Ceape Ave, Oshkosh 54901

WOOD: Robert L Johnson, 452 Greenwood Drive, Wisconsin Rapids 54494; Francis Kruse, Jr, 630 S Central Ave, Marshfield 54449

All officers above are MDs unless labeled Mr

WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY OF WISCONSIN

State Officers and Directors for 1972–1973

OFFICERS

President ..... MRS. WILLIAM C. JANSSEN
11541 N. Shorecliff Lane, Mequon 53092

President-Elect ..... MRS. ROBERT JOHNSTON
3285 Waubenoor Drive, Green Bay 54301

Vice-President ..... MRS. ROBERT CULLEN
86 Elm Acres Drive, Fond du Lac 54935

Recording Secretary ..... MRS. GEORGE MEISINGER
Route 3, Box 233C, Fond du Lac 54935

Corresponding Secretary .. MRS. BERNARD SCHAEFFER
6220 N. Santa Monica Blvd., Milwaukee 53217

Treasurer ..... MRS. ALWIN SCHULTZ
6221 N. Highlands Avenue, Madison 53705

Immediate Past President .... MRS. D. G. MacMILLAN
2097 Quant Avenue, North, Stillwater, Minnesota 55082

DIRECTORS

MRS. KAREL CEJPEK, 325 S. 14th, La Crosse 54601

MRS. ROBERT LOTZ, 105 Skyline Drive, Eau Claire 54701

MRS. JOHN MIELKE, 6 Hycrest Court, Appleton 54911

MRS. DONALD ROWE, 527 Center Lane, Kohler 53044

MRS. JACK L. TEASLEY, 7421 N. Crossway Road, Milwaukee 53217

EXECUTIVE SECRETARY

MRS. LaVERNE BARTEL, 330 E. Lakeside Street, Madison 53715

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES

WISCONSIN ALLERGY SOCIETY

President—Jordon Fink, MD (May 1973), Milwaukee
Secretary—S. R. Hirsch, MD (May 1973), Milwaukee

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

President—Frederick Carpenter, MD (Oct. 1973), Wauwatosa
Secretary—Ruth A. Stoerker, MD (Oct. 1973), Madison

WISCONSIN DERMATOLOGICAL SOCIETY

President—Robert B. Pittelkow, MD (Oct. 1973), Milwaukee
Secretary—Stephen Webster, MD (Oct. 1973), La Crosse

WISCONSIN ACADEMY OF FAMILY PHYSICIANS

President—Richard W. Shropshire, MD (Sept. 1973), Madison
Secretary—N. F. Damiano, MD (Sept. 1973), Hales Corners
Executive Secretary—Mr. Robert H. Herzog (Sept. 1973), Milwaukee

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President—Robert F. Madden, MD (Sept. 1973), Milwaukee
Secretary—George E. Owen, MD (Sept. 1973), Eau Claire
Executive Secretary—Mr. Donald L. McNeil (Sept. 1973), Milwaukee

WISCONSIN NEUROLOGICAL SOCIETY

President—Harold E. Booker, MD (June 1973), Madison
Secretary—Gastone G. Celesia, MD (June 1973), Madison

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY

President—Herbert Sandmire, MD (Oct. 1973), Green Bay
Secretary—W. J. O'Leary, MD (Oct. 1973), La Crosse

WISCONSIN ORTHOPEDIC SOCIETY

President—Paul W. Phillips, MD (Sept. 1973), La Crosse
Secretary—Stephan L. Haug, MD (Sept. 1973), La Crosse

WISCONSIN OTOLARYNGOLOGICAL SOCIETY

President—James H. Brandenburg, MD (Sept. 1973), Madison
Secretary—T. J. Donovan, MD (Sept. 1973), Madison

WISCONSIN SOCIETY OF PATHOLOGISTS

President—Chesley Erwin, MD (Nov. 1973), Elm Grove
Secretary—Roland C. Brown, MD (Nov. 1973), Milwaukee

WISCONSIN ACADEMY OF PEDIATRICS

President—John R. Guy, MD (May 1973), Waukesha
Secretary—George G. Griese, MD (May 1973), Marshfield

WISCONSIN SOCIETY OF PLASTIC SURGERY

President—Gordon Davenport, MD (no official term), Madison
Secretary—J. E. Hamacher, MD (no official term), Madison

WISCONSIN PSYCHIATRIC ASSOCIATION

President—Raymond Headlee, MD (May 1973), Elm Grove
Secretary—D. T. Fullerton, MD (May 1973), Marshfield

WISCONSIN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

President—G. P. Ferrazzano, MD (May 1973), Racine
Secretary—Josef Preizler, MD (May 1973), Madison

WISCONSIN RADIOLOGICAL SOCIETY

President—Andrew B. Crummy, MD (Sept. 1973) Madison
Secretary—Marvin Hinke, MD (Sept. 1973), Marshfield

WISCONSIN SURGICAL SOCIETY

President—Wayne Boulanger, MD (May 1973), Milwaukee
Secretary—P. Richard Sholl, MD (May 1973), Janesville

WISCONSIN SOCIETY OF THERAPEUTIC RADIOLOGISTS

President—Frank Ellis, MD (Nov. 1973), Milwaukee
Secretary—Robert W. Edland, MD (Nov. 1973), La Crosse

WISCONSIN UROLOGICAL SOCIETY

President—Richard H. Troup, MD (May 1973), Green Bay
Secretary—John D. Silbar, MD (May 1973), Milwaukee

OFFICERS OF SCIENTIFIC SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON ANESTHESIOLOGY

Chairman ..... Frederick J. Carpenter, Milwaukee
Secretary ..... Ruth A. Stoerker, Madison
Delegate ..... Robert E. Holzgrafe, Waukesha
Alternate ..... John W. Temple, Milwaukee

SECTION ON DERMATOLOGY

Chairman ..... Robert B. Pittelkow, Milwaukee
Secretary ..... Stephen B. Webster, La Crosse
Delegate ..... Joel E. Taxman, Milwaukee
Alternate ..... Robert R. Baumann, Monroe

SECTION ON FAMILY PHYSICIANS

Chairman ..... Richard W. Shropshire, Madison
Secretary ..... Nicholas F. Damiano, Hales Corners
Delegate ..... Norbert G. Bauch, Milwaukee
Alternate ..... John O. Grade, Elm Grove

SECTION ON INTERNAL MEDICINE

Chairman ..... Robert F. Madden, Milwaukee
Secretary ..... George E. Owen, Eau Claire
Delegate ..... James A. Means, Milwaukee
Alternate ..... William L. Treacy, Milwaukee

SECTION ON MEDICAL FACULTIES

Delegate ..... John Arkins, Milwaukee
Alternate ..... John H. Juhl, Madison

SECTION ON NEUROLOGY AND PSYCHIATRY

Chairman ..... Raymond Headlee, Elm Grove
Secretary ..... Vacancy
Delegate ..... Carroll W. Osgood, Wauwatosa
Alternate ..... Stanley Miezio, Madison

SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman ..... Herbert F. Sandmire, Green Bay
Secretary ..... William J. O'Leary, Jr., La Crosse
Delegate ..... William E. Martens, Wauwatosa
Alternate ..... Robert P. Reik, Wauwatosa

SECTION ON OPHTHALMOLOGY

Chairman ..... W. Carson Parks, Milwaukee
Secretary ..... Herbert Giller, Milwaukee
Delegate ..... Duane E. Mings, Monroe
Alternate ..... Gordon L. Backer, Wausau

SECTION ON ORTHOPEDICS

Chairman ..... Paul W. Phillips, La Crosse
Secretary ..... Stephen L. Haug, La Crosse
Delegate ..... Paul A. Jacobs, Milwaukee
Alternate ..... Peter B. Golden, Madison

All the above are MDs and members of the State Medical Society of Wisconsin.

SECTION ON OTOLARYNGOLOGY

Chairman ..... Roger H. Lehman, Wood
Secretary ..... Timothy J. Donovan, Madison
Delegate ..... Thomas W. Grossman, Milwaukee
Alternate ..... John M. Mills, Green Bay

SECTION ON PATHOLOGY

Chairman ..... Chesley P. Erwin, Elm Grove
Secretary ..... Roland C. Brown, Wauwatosa
Delegate ..... Robert E. Carlovsky, Fond du Lac
Alternate ..... Edward A. Burg, Jr., Milwaukee

SECTION ON PEDIATRICS

Chairman ..... John R. Guy, Waukesha
Secretary ..... George G. Griese, Marshfield
Delegate ..... Richard L. Myers, Green Bay
Alternate ..... Victor J. Cordes, Wauwatosa

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

Chairman ..... James F. McDermott, Wauwatosa
Secretary ..... Morris Mitz, Milwaukee
Delegate ..... Albert M. Cohen, Milwaukee
Alternate ..... Vacancy

SECTION ON PLASTIC SURGERY

Chairman ..... Gordon Davenport, Jr., Madison
Secretary ..... John E. Hamacher, Madison
Delegate ..... Ruedi P. Gingrass, Milwaukee
Alternate ..... Paul Natvig, Milwaukee

SECTION ON PUBLIC HEALTH

Chairman ..... Gabriel P. Ferrazzano, Racine
Secretary ..... Arthur L. Van Duser, Madison
Delegate ..... Gertrude E. Howe, Madison
Alternate ..... George H. Handy, Madison

SECTION ON RADIOLOGY

Chairman ..... Andrew B. Crummy, Jr., Madison
Secretary ..... Marvin L. Hinke, Marshfield
Delegate ..... Frederick M. Rich, Madison
Alternate ..... Robert C. Feulner, Waukesha

SECTION ON SURGERY

Chairman ..... Wayne L. Boulanger, Milwaukee
Secretary ..... P. Richard Sholl, Janesville
Delegate ..... Thomas J. Beno, Green Bay
Alternate ..... George F. Pratt, Rhinelander

SECTION ON UROLOGY

Chairman ..... Richard H. Troup, Green Bay
Secretary ..... John D. Silbar, Milwaukee
Delegate ..... John W. Kearns, Milwaukee
Alternate ..... Charles L. Weisenthal, Milwaukee

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 448.02 (1), 448.03 (3), 448.16, and 448.21, Wisconsin Statutes.

Recipients of Awards Presented by the State Medical Society of Wisconsin

COUNCIL AWARD

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, MD† 1930
Cornelius A. Harper, MD† 1930
John J. McGovern, MD† 1931
Louis M. Jermain, MD† 1931
Edward Evans, MD† 1931
Mina B. Glasier, MD† 1932
Arthur W. Rogers, MD† 1934
Rock Sleyster, MD† 1934
Olin West, MD† 1934
Edward A. Birge, PhD† 1935
Arthur J. Patek, MD† 1935
Joseph F. Smith, MD† 1937
Eben J. Carey, MD† 1938
William S. Middleton, MD 1938
Fred G. Johnson, MD† 1939
William D. Stovall, MD† 1940
Ludvig Hektoen, MD*† 1941
Stephen E. Gavin, MD† 1944
F. Gregory Connell, MD† 1947
E. R. Schmidt, MD† 1949
Armand J. Quick, MD 1950
F. A. Stratton, MD† 1951
Gunnar Gundersen, MD 1953
W. J. Meek, PhD† 1953
R. G. Arveson, MD† 1957
Edwin B. Fred, PhD 1958
Harry Beckman, MD 1959
Elizabeth Comstock, MD† 1961
Harry Steenbock, PhD† 1963
Francis J. L. Blasingame, MD 1964
C. N. Neupert, MD† 1965
Spencer D. Beebe, MD† 1965
Frank L. Weston, MD** 1966
Robert E. Fitzgerald, MD**† 1966
William B. Walsh, MD 1967
H. Kent Tenney, MD 1969
Charles H. Crownhart, Esq. 1971

* Centennial Award. † Deceased.
** 125th Anniversary Award.

DISTINGUISHED SERVICE AWARD

The Council, upon recommendation of the Commission on Scientific Medicine, may on occasion grant the Distinguished Service Award in recognition of outstanding contributions to the science and art of medicine by individuals engaged in teaching and research in the basic sciences.

Armand J. Quick, MD, Milwaukee 1964
Otto A. Mortenson, MD, Madison 1967
Walter Zeit, PhD, Milwaukee 1972

PRESIDENTIAL CITATION AWARD

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a non-physician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission) 1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library) 1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) 1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette 1965
Francis J. Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire 1966
Warren P. Knowles (Governor of the State of Wisconsin), Madison 1967
Leo C. Massopust (Scientific photographer, artist, and editor), Milwaukee 1968
Karl F. Schmidt, PhD (Associate Director for Radio [WHA] at University of Wisconsin), Madison .. 1969
The Most Rev. Father Carl Mansfeld, Milwaukee.. 1970
Roy T. Ragatz (Executive Director, Interstate Postgraduate Medical Association), Madison 1971
The Hon. John W. Byrnes (U.S. Congressman from Wisconsin), Green Bay 1972

CIVIC LEADERSHIP AWARD

Established by the Council in 1972, the Civic Leadership Award recognizes a member of the State Medical Society of Wisconsin for his outstanding contributions in the activities of his community and the medical society.

John M. Bell, MD, Marinette 1972

BEAUMONT MEMORIAL LECTURE AWARD

Established in 1957 by the Council to memorialize one of Wisconsin's early frontier surgeons. Sponsored by the Society's Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. Lecturers are selected by the Commission on Scientific Medicine for participation in the Annual Meeting scientific program.

Burill B. Crohn, MD, New York, N. Y. 1958
Franz J. Ingelfinger, MD, Boston, Mass. 1959
Mr. Charles W. A. Falconer, Edinburgh, Scotland .. 1960
J. L. A. Roth, MD, Philadelphia, Pa. 1961
Ivan Baranofsky, MD, San Diego, Calif. 1963
David Y-Yung Hsia, MD, Chicago, Ill. 1964
Alton Ochsner, MD, New Orleans, La. 1965
Michael DeBakey, MD, Houston, Tex. 1966
F. A. Simeone, MD, Cleveland, Ohio 1967
John S. Najarian, MD, Minneapolis, Minn. 1968
Oliver H. Beahrs, MD, Rochester, Minn. 1969
Warner S. Bump, MD, Rhinelander, Wis. 1970
John P. Wyatt, MD, Winnipeg, Manitoba, Canada 1971
Richard H. Egdahl, MD, Boston, Mass. 1972

ELVEHJEM MEMORIAL LECTURE AWARD

Established in 1962 by the Council to honor the memory of Conrad A. Elvehjem, PhD, the thirteenth president of the University of Wisconsin and an international authority in biochemistry. It is presented through auspices of the Society's Charitable, Educational and Scientific Foundation and is designed to perpetuate Doctor Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. Lecturers are selected by the Commission on Scientific Medicine for participation in the Annual Meeting scientific program.

Fredrick J. Stare, MD, Boston, Mass. 1963
John B. Henry, MD, Syracuse, N.Y. 1965
Jeremiah Stamler, MD, Chicago, Ill. 1967
David Y-Yung Hsia, MD, Chicago, Ill. 1968
James E. McGuigan, MD, Gainesville, Fla. 1970
Harry S. Jacob, MD, Minneapolis, Minn. 1971
A. L. Schroeter, MD, Rochester, Minn. 1972

HOUGHTON MEDICAL STUDENT AWARD

Granted annually to a student from each of Wisconsin's two medical schools who, through scholastic excellence, extracurricular achievement, and interest in medical organization, show high promise of becoming a complete physician. Established by MDs John H. and William J. Houghton, brothers, who were councilors of the State Medical Society of Wisconsin; John H. also was president. Established in 1968 through funds contributed to the Society's Charitable, Educational and Scientific Foundation.

James Renne, Kenosha (University of Wisconsin Medical School) 1968
C. Robert Stanhope, Milwaukee (Marquette School of Medicine) 1968
Bruce D. Buchanan (Marquette School of Medicine) 1969
Daniel D. Kane (University of Wisconsin Medical School) 1969
Stephen A. Bernsten, Skokie, Ill. (University of Wisconsin Medical School) 1970
Arthur W. Kaemmer, Fond du Lac (Marquette School of Medicine) 1970
Winston Hollister, Milwaukee (Medical College of Wisconsin) 1971
Daniel Leicht, Racine (UW Medical School) 1971
James B. Johnson (Medical College of Wisconsin) 1972
Eliot J. Huxley (UW Medical School) 1972

GUNNAR GUNDERSEN GOLD MEDALLION AWARD

Established in 1966 during the State Medical Society's 125th anniversary to honor one of Wisconsin's most distinguished physicians and citizens, Gunnar Gundersen, MD of La Crosse, who is a former president of the American Medical Association and the State Medical Society of Wisconsin. Presented by the Society for the scientific exhibit judged to be the most outstanding teaching exhibit in surgery at the Annual Meeting.

Joseph C. Darin, MD, Wauwatosa *(Extracorporeal Hepatic Support System)* 1967
Flavio Puletti, MD, Madison *(Stereotactic Surgery in Parkinson's Disease)* 1968
Allen J. Pois, MD; John Morledge, MD; Gordon A. Tuffli, MD; and Peter Rank, MD; Jackson Clinic and Methodist Hospital, Madison *(Atrial Septal Defect, Diagnosis and Treatment)* 1969
William M. Toyama, MD, Marshfield *(Open Pulmonary Biopsy in Children)* 1970
Robert J. Flemma, MD; G. W. Beddingfeld, MD; Derward Lepley, Jr., MD; Jack C. Manley, MD; Howard J. Zeft, MD; Henry H. Gales, MD; H. David Friedberg, MD; W. Dudley Johnson, MD; Alfred J. Tector, MD; John A. Walker, MD; Donald R. McRaven, MD; John H. Huston, MD; Felix E. Tristani, MD; Ramon L. Lange, MD; and Michael H. Keelan, MD; Medical College of Wisconsin; St. Luke's Hospital; Veterans Administration Hospital; and Milwaukee County General Hospital, Milwaukee *(Aorto-Coronary Bypass Grafts—Early and Late Followup Studies)* .. 1972

ERWIN R. SCHMIDT INTERSTATE TEACHING AWARD

Since 1966, presented annually by the Interstate Postgraduate Medical Association to a faculty member of one of the two Wisconsin medical schools who has distinguished himself as a teacher of medical students and in preparing them for both the art and practice of medicine. Selected upon recommendation of the Commission on Scientific Medicine, the Award is given in honor of Erwin R. Schmidt, MD, who was chairman of surgery at the University of Wisconsin Medical School.

William S. Middleton, MD, Madison 1966
Walter Zeit, PhD, Milwaukee 1967
Paul F. Clark, PhD, Madison 1968
Walter P. Blount, MD, Milwaukee 1969
Ovid O. Meyer, MD, Madison 1970
William W. Engstrom, MD, Milwaukee 1971
Otto A. Mortenson, MD, Madison 1972

TAX DEDUCTIBILITY OF HEALTH AND ACCIDENT INSURANCE

One-half of medical care insurance premiums up to a maximum of $150.00 are fully deductible. Additional medical care premiums may be included with other medical expenses and are subject to the limited deduction of the excess of medical expenses over 3% of adjusted gross income.

Premiums paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, are deductible medical expenses only to the extent allocable to medical care and *only* if the charge for medical care is separately stated in the policy or in a statement sent to the policyholder by the insurance company. In addition, the charge for medical care on a combination policy is eligible for a medical expense deduction only if not unreasonably large in relation to the total premium under the contract.

All taxpayers, whatever their age, are subject to the same general rules. The same rules as are set out above also apply for 1972 Wisconsin income tax purposes.

Past Presidents of the State Medical Society

Mason C. Darling, M.D., Fond du Lac.....1841–1847
John B. Dousman, M.D., Milwaukee.....1847–1849
Alfred L. Castleman, M.D., Delafield.....1849–1851
Harmon Van Dusen, M.D., Mineral Point...1851–1854
Alfred L. Castleman, M.D., Delafield.....1854–1855
John Mitchell, M.D., Janesville.....1855–1856
David Cooper Ayres, M.D., Green Bay.....1856–1857
Clark G. Pease, M.D., Janesville.....1857–1859
Ezra S. Carr, M.D., Madison.....1859–1861
Solomon Blood, M.D., Rochester.....1861–1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, M.D., Mineral Point....1867–1869
Solon Marks, M.D., Milwaukee.....1869–1870
Henry P. Strong, M.D., Beloit 1870–1871
John Favill, M.D., Madison.....1871–1872
Harmon Van Dusen, M.D., Mineral Point....1872–1873
Marvin Waterhouse, M.D., Portage.....1873–1874
James T. Reeve, M.D., Appleton.....1874–1875
Joseph B. Whiting, M.D., Janesville.....1875–1876
John K. Bartlett, M.D., Milwaukee.....1876–1877
Darius Mason, M.D., Prairie du Chien.....1877–1878
Nicholas Senn, M.D., Milwaukee.....1878–1879
John G. Meachem, Sr., M.D., Racine.....1879–1880
Ira Manley, Jr., M.D., Markesan.....1880–1881
William Meacher, M.D., Portage.....1881–1882
Thomas P. Russell, M.D., Oshkosh.....1882–1883
Nelson M. Dodson, M D., Berlin.....1883–1884
Edwin W. Bartlett, M.D., Milwaukee.....1884–1885
G. M. Steele, M.D., Oshkosh.....1885–1886
Samuel C. Johnson, M.D., Hudson.....1886–1887
Leroy G. Armstrong, M.D., Boscobel.....1887–1888
John R. Barnett, M.D., Neenah.....1888–1889
Ezra M. Rogers, M.D., Hartford.....1889–1890
George D. Ladd, M.D., Milwaukee.....1890–1891
George F. Witter, M.D., Grand Rapids
(Wisconsin Rapids).....1891–1892
Benjamin T. Phillips, M.D., Menominee, Mich..1892–1893
Benjamin C. Brett, M.D., Green Bay.....1893–1894
Almon Clarke, M.D., Sheboygan.....1894–1895
Frank W. Epley, M.D., New Richmond.....1895–1896
B. O. Reynolds, M.D., Lake Geneva.....1896–1897
William Mackie, M.D., Milwaukee.....1897–1898
Herman Reineking, M.D., Milwaukee.....1898–1899
Wilbur T. Sarles, M.D., Sparta.....1899–1900
John F. Pritchard, M.D., Manitowoc.....1900–1901
Walter H. Neilson, M.D., Milwaukee.....1901–1902
John V. R. Lyman, M.D., Eau Claire.....1902–1903
Franklin E. Walbridge, M.D., Milwaukee.....1903–1904
Charles W. Oviatt, M.D., Oshkosh.....1904–1905
John R. Currens, M.D., Two Rivers.....1905–1906
Levi H. Pelton, M.D., Waupaca.....1906–1907
William E. Ground, M.D., Superior.....1907–1908
Gilbert E. Seaman, M.D., Madison.....1908–1909
Edward Evans, M.D., La Crosse.....1909–1910
Byron M. Caples, M.D., Waukesha.....1910–1911
John M. Dodd, M.D., Ashland.....1911–1912
Arthur J. Patek, M.D., Milwaukee.....1912–1913
Charles S. Sheldon, M.D., Madison.....1913–1914
Theodore J. Redelings, M.D., Marinette.....1914–1915
Louis J. Jermain, M.D., Milwaukee.....1915–1916
Hoyt E. Dearholt, M.D., Milwaukee.....1916–1917
Gustave Windesheim, M.D., Kenosha.....1917–1918
Dennis J. Hayes, M.D., Milwaukee.....1918–1919
Charles R. Bardeen, M.D., Madison.....1919–1920
Henry W. Abraham, M.D., Appleton*.....1920
Matthew A. McGarty, M.D., La Crosse.....1920–1921
Sidney Hall, M.D., Ripon.....1921–1922
F. Gregory Connell, M.D., Oshkosh.....1922–1923
Rock Sleyster, M.D., Wauwatosa.....1923–1924
Wilson Cunningham, M.D., Platteville.....1924–1925
Joseph F. Smith, M.D., Wausau.....1925–1926
Arthur W. Rogers, M.D., Oconomowoc.....1926–1927
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A. J. McDowell, M.D., Soldiers Grove†.....1930
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Otho Fiedler, M.D., Sheboygan.....1931–1932
Reginald H. Jackson, M.D., Madison.....1932–1933
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Francis E. Butler, M.D., Menomonie.....1942–1943
Russell M. Kurten, M.D., Racine.....1943–1944
Charles Fidler, M.D., Milwaukee.....1944–1945
P. R. Minahan, M.D., Green Bay.....1945–1946
Charles A. Dawson, M.D., River Falls.....1946–1947
William D. Stovall, M.D., Madison.....1947–1948
Karl H. Doege, M.D., Marshfield 1948–1949
John W. Truitt, M.D., Milwaukee.....1949–1950
Henry H. Christofferson, M.D., Colby.....1950–1951
Albian H. Heidner, M.D., West Bend.....1951–1952
Joseph C. Griffith, M.D., Milwaukee.....1952–1953
H. Kent Tenney, M.D., Madison.....1953–1954
Arthur J. McCarey, M.D., Green Bay‡.....1954–1955
Ervin L. Bernhart, M.D., Milwaukee.....1955–1956
L. O. Simenstad, M.D., Osceola.....1956–1957
Harry E. Kasten, M.D., Beloit.....1957–1958
Jerome W. Fons, M.D., Milwaukee.....1958
William B. Hildebrand, M.D., Menasha.....1959–1960
Edmund D. Sorenson, M.D., Elkhorn.....1960–1961
Leif H. Lokvam, M.D., Kenosha.....1961–1962
Nels A. Hill, M.D., Madison.....1962–1963
William J. Egan, M.D., Milwaukee.....1963–1964
William P. Curran, M.D., Antigo.....1964–1965
J. H. Houghton, M.D., Wisconsin Dells.....1965–1966
Frank E. Drew, M.D., Milwaukee.....1966–1967
H. J. Kief, MD, Fond du Lac.....1967–1968
W. D. James, MD, Oconomowoc 1968–1969
Robert E. Callan, MD, Milwaukee 1969–1970
Jerry W. McRoberts, MD, Sheboygan 1970–1971
George A. Behnke, MD, Kaukauna 1971–1972

* *Died during term of office as president-elect.*

† *Resigned, because of health, prior to taking office.*

‡ *Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year*

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

State Medical Society of Wisconsin

SPEAKERS SERVICE

for

COUNTY MEDICAL SOCIETY MEETINGS

and

COUNCILOR DISTRICT MEETINGS

County medical societies are urged to use this service which is now in its tenth consecutive year of operation. Speakers from throughout the state as well as those from the two medical schools and the State Division of Health are available through application to the State Medical Society. Applications must be filed at least 30 days before a meeting in order to qualify the speaker for an honorarium and travel expenses. (No speakers are furnished during February and March.)

All areas of scientific medicine are represented, and societies are urged to arrange for at least four scientific programs per year.

Other subjects on which speakers are available include legislation, health insurance, interprofessional meetings, school health, mental health, care of the aged, occupational health, medical press relations, maternal mortality, glaucoma detection, cancer and heart, orthopedic and heart clinics, Wisconsin Health Care Review, Inc., and PSROs—professional standards review organizations.

Request application forms from S. E. Sivertson, MD, Chairman, Commission on Scientific Medicine, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Sponsored by

COMMISSION ON SCIENTIFIC MEDICINE AND CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY

in cooperation with

POSTGRADUATE PROGRAM OF MERCK SHARP & DOHME, WISCONSIN DIVISION OF HEALTH, AMERICAN CANCER SOCIETY—WISCONSIN DIVISION, THE MEDICAL COLLEGE OF WISCONSIN, AND THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

POISON INFORMATION CENTERS . . .

- approved by the Wisconsin Department of Health and Social Services, Division of Health, offer information on the chemical composition of brand-name products on a 24-hour day basis. Files are provided and kept up-to-date by the National Clearinghouse for Poison Control.
- recommend treatment to professional people or in certain emergencies, first aid procedure to lay callers.
- provide treatment for patients.
- keep a record of calls received, treatment advised or given, and disposition of case.
- report monthly to the Division of Health.

are located at:

Eau Claire
Luther Hospital
Phone: (715) 832–6611 Ext. 227

Green Bay
Bellin Memorial Hospital
Phone: (414) 437–9031 Ext. 257

Kenosha
Kenosha Memorial Hospital
Phone: (414) 656–2201

Madison
University Hospitals
Phone: (608) 262–3702

Milwaukee
Children's Hospital
Phone: (414) 344–7100 Ext. 308

POISON CONTROL CENTERS . . .

- exist in many hospitals, including those listed above as Poison Information Centers. Not all Poison Control Centers are set up to give 24-hour service.
- provide treatment for patients.
- have standard references on toxicology and can answer many questions about potential poisons and treatment of cases. However, they do not have a complete file of the chemical composition of brand-name products such as the Poison Information Centers have.

This information provided by the
WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
P. O. Box 309 Madison, Wis. 53701

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation

of the

State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for these loans have been given to the Foundation to administer according to the wishes of the donors. See the adjacent box.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides a ten-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

MUSEUM OF MEDICAL PROGRESS. One of the most extensive and on-going public health education efforts in Wisconsin has been made possible by the Foundation's development of the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical socio-economic nature.

SCIENTIFIC MEDICINE. Scientific activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor. All contributions to the Foundation are deductible for income tax purposes.

STUDENT LOAN FUNDS

available from the Charitable, Educational and Scientific Foundation

STATE MEDICAL SOCIETY OF WISCONSIN

Here is a list of student loan funds designed to aid Wisconsin students in medicine, dentistry, nursing, pharmacy and allied medical fields. These loan funds have been donated by individual physicians, county medical societies, personal memorials, and from other sources. In some instances, the CES Foundation acts as administrator of loan funds for other organizations or institutions.

These long term, low interest loans usually are limited to $500 per semester for a total of three years and generally are granted only when other sources of aid are unavailable. No interest is charged until two years after graduation from the professional school in which the student was enrolled.

Your contributions to any of these or the start of new funds can help the Foundation serve more deserving young people. Your check should be made payable to the Charitable, Educational and Scientific Foundation, specifying the particular fund you are supporting.

The funds and their requirements are shown at the right.

Interested persons are urged to contact the Charitable, Educational and Scientific Foundation, Box 1109, Madison, Wisconsin 53701.

FUND	*FOR EDUCATION IN:*	*APPLICANTS MUST BE RESIDENT OF:*
General Loan Fund	Medicine	Wisconsin
Brown County Medical Auxiliary Loan Fund	Medicine Allied Medical Fields	Wisconsin
Dane County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Dane County
Grant County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Grant County
Green County Medical Society Student Loan Fund	Medicine	Green County
Jefferson County Medical Society Nursing Fund	Nursing	Jefferson County
Kenosha County Medical Society Medical Student Loan Fund	Medicine	Kenosha County
Marinette County Medical Society Health Careers Loan Fund	Medicine Nursing	Marinette County
Outagamie County Medical Society Health Careers Loan Fund	Medicine Allied Medical Fields	Outagamie County
Trempealeau County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Trempealeau County
Charles H. Crownhart State Student Loan Fund	Medicine	Wisconsin
Quincy Danforth, MD, Medical Student Loan Fund	Medicine	Wisconsin
W. W. Hildebrand, Esq., and G. B. Hildebrand, MD, Memorial Account	Medicine	Wisconsin
Reuben Knutson Student Loan Fund	Medicine	Wisconsin
Menominee County Loan Fund (Ruth Coe, RN)	Nursing and Similar Health Fields	Menominee County
Albert Popp, MD, Student Loan Fund	Medicine (Medical College of Wisconsin students receive priority)	No residency qualifications
Cyrus G. Reznichek, MD, Student Loan Fund	Medicine (UW Med. School, MCOW, & Northwestern Med. School) Dentistry (Marquette School of Dentistry)	Wisconsin
Barbara P. Sargent Memorial Nursing Loan Fund	Nursing	Wisconsin
Beverly Schuster Memorial Fund	Nursing or Paramedical	Racine County
Wisconsin Academy of Family Physicians Loan Fund	Medicine (For students planning to be general practitioners)	Wisconsin

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION

OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society, one representative from each of the 54 component county societies, and up to ten elected non-medical persons. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected Trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

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A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

Department of Health and Social Services

ADDRESS: 1 West Wilson St., Madison, Wis. 53702 TELEPHONE: (608) 266–3681

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* Not officially confirmed—no date available.

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continued on next page

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No. 2—9618 West Greenfield Ave.; Phone (414) 258–8323 ..... West Allis 53214
No. 3—485 South Military Rd.; P. O. Box 269; Phone (414) 922–1290 .. Fond du Lac 54935
No. 4—1181 Western Ave.; P. O. Box 3730; Phone (414) 494–9571 ..... Green Bay 54303
No. 5—District State Office Building, 3550 Mormon Coulee Rd.;
Phone (608) 788—0700 ..... La Crosse 54601
No. 6—District State Office Building, 718 West Clairemont Ave.;
Phone (715) 834–2931 ..... Eau Claire 54701
No. 7—District State Office Building, 1681 Second Ave. South, P. O. Box 270;
Phone (715) 423–4730 ..... Wisconsin Rapids 54494
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No. 8—Information should be obtained from Eau Claire District

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John P. Purcell, District Supervisor

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Rodney R. Van Deventer, District Supervisor; tel. (608) 266–3543

Madison Central Office: 122 West Washington Ave., Madison 53703; tel. (608) 266–3054
Dennis Bobo, Rehabilitation Supervisor

Janesville Local Office: 101 South Main St., Janesville 53545; tel. (608) 754–2861
Wayne Olson, Rehabilitation Supervisor

University Counseling: 1800 University Ave., Madison 53706; tel. (608) 266–3926
Patrick Mommaerts, Rehabilitation Supervisor

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William R. Newberry, District Supervisor

Milwaukee County Mental Health Center, 9035 Watertown Plank Rd., Milwaukee 53226; tel. (414) 258–2040, ext. 3161
Janice Petrus, Rehabilitation Supervisor

Public Assistance Project, 2201 North 3rd St., Milwaukee; tel. (414) 263–2446
Gilbert Chrisien, Rehabilitation Supervisor

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James A. Mather, District Supervisor

Fond du Lac Local Office: 485 South Military Rd., Fond du Lac 54935; tel. (414) 921–5883
Paul Monzel, Rehabilitation Supervisor

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100 Second St., West (54806); tel. (715) 682–3404

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LA CROSSE: Alfred Hebert, District Administrator
P.O. Box 743, 250 Mormon Coulee Rd. (54601); tel. (608) 788–1000

MADISON: Robert D. Albrecht, District Administrator
1206 Northport Drive; tel. (608) 249–0441

MILWAUKEE: Mrs. Georgia Caviale, District Administrator
2715 West Wisconsin Ave. (53208); tel. (414) 344–4023

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P.O. Box 632, 1681 Second Ave., South (54494); tel. (715) 423–4305

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes.

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PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (1) (b), Wisconsin Statutes.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 979.121, Wisconsin Statutes.

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Interested in a Working Vacation Abroad?

Some of the major organizations sponsoring volunteer physicians abroad are listed here for the benefit of Wisconsin physicians wishing to spend vacations in other countries where their medical knowledge and help are needed. Interested physicians should contact directly the sponsoring organization of their choice for further information.

- **Volunteer Physicians for Viet Nam,** 535 North Dearborn St., Chicago, Ill. 60610.
- **Project HOPE,** The People-to-People Health Foundation, Inc., 2233 Wisconsin Ave., Washington, D.C. 20007.
- **AmDoc, Inc.,** 27 E. Cannon Perdido St., Santa Barbara, Calif. 93101.
- **FOCUS, Inc.** (Ophthalmologists), 1431 Ashland Ave., River Forest, Ill. 60305.
- **Project Concern, Inc.,** P.O. Box 2468, San Diego, Calif. 92112.
- **Medical Assistance Programs, Inc.,** Box 50, Wheaton, Ill. 60187.
- **Catholic Medical Mission Board,** 10 W. 17th St., New York, 10011.
- **Christian Medical Council for Overseas Work,** National Council of the Churches of Christ in the USA, 475 Riverside Dr., New York 10027.
- **World Brotherhood Exchange,** Lutheran Council in the USA, 315 Park Ave. S., New York 10010.
- **Operation Crossroads Africa, Inc.,** 150 Fifth Ave., New York 10011.
- **MEDICO,** Orthopaedics Overseas Division, 2007 Eve St., NW, Washington, D.C. 20006.
- **Holidays for Humanity, Inc.,** 3700 Bellemeade Ave., Suite 105, Evansville, Ind. 47715.
- **Direct Relief Foundation,** P.O. Box 1319, Santa Barbara, Calif. 93102.

THIRTEEN AIDS IN AVOIDING LAWSUITS

In a recent article in *Resident and Staff Physician* (June, 1970), Gene Balliett, president of a management consultant firm, presented thirteen points to aid in avoiding a malpractice suit. Once professional liability insurance has been bought and the policy carefully read, the following steps are recommended when problems arise with a case:

1. **Alert your insurer.** Notify him as soon as an accident occurs, instead of waiting until you receive notice of an impending lawsuit.
2. **Keep your insurance coverage to yourself.** Do not invite a malpractice suit by announcing to others the extent of your insurance coverage.
3. **Admit an honest mistake—but not legal liability.** Admitting an honest mistake is not the same as assuming liability. A court of law is responsible for determining liability.
4. **When you do err, avoid the risk of making an even bigger error—that of trying to cover up.** Even after making an error, continue to practice good medicine. A court may forgive an honest mistake, but usually will not rule favorably if a mistake is compounded by an effort to cover it up.

   For guidance with a specific case, the best initial source of advice is your professional liability insurer.
5. **Refer the plaintiff's attorney to your own.** Allow the lawyers to talk together, with the physician staying out of the conversation as much as possible.
6. **If a case doesn't go quite right, think twice about turning the patient's account over for collection.** Employing a collection agency often is the action which finally pushes a patient into bringing charges against a physician.

Additional suggestions in avoiding a lawsuit include:

7. **Learn to recognize a suit-prone patient.** Special care should be taken with patients who show an over-concern with money, unusually pointed criticism of one or more previous doctors, suspicion, and an unrealistic expectation of good results.
8. **Proceed only with a patient's informed consent.** A physician cannot legally proceed unless informed consent is obtained from the patient.
9. **Practice within the limits of your competence.** If a physician presents himself as a specialist, he must practice as a competent specialist.
10. **Be slow to guarantee a good result.** If care is taken while discussing a case or procedure with a patient, there is less chance of being held for breach of oral contract.
11. **Keep good records.** Extensive, accurate records are a necessity if a case is brought to court.
12. **See a case through once you start.** Once a physician begins to see a patient, he cannot abandon him without being held responsible for him.
13. **Head off assistant's errors.** The physician is responsible for anything done by anyone who works for him.

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State Medical Society of Wisconsin

MARCH 26–27

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Highlights of Scientific Program

THEME: EVALUATION AND THERAPY OF COMMON ENDOCRINE DISORDERS

Monday, March 26

A.M. Plenary Session, Sections on Family Physicians, Internal Medicine, Pediatrics

Noon Socio-economic Luncheon. Speaker to be announced.

P.M. Plenary Session, Wisconsin Allergy Society, Sections on Dermatology and Public Health

Tuesday, March 27

A.M. Resident–Intern Papers Program
Plenary Session, Sections on Pathology and Radiology

Noon Roundtable Luncheons

P.M. Anesthesia, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Pathology, Radiology, Surgery

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The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexe in "Index Medicus" and "Hospital Literature Index," an its contents page appears regularly in "Current Contents Clinical Practice."

ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Division of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Division of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes.

★

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No calculations are needed, test interpretation is simple.

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TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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Side effects, when they do occu are related to excessive dosage Caution should be exercised in administering the drug to patier with cardiovascular disease. Re the accompanying prescribing information for additional data write Flint Laboratories.

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›xine (T_4) is, as you know, ıajor circulating hormone ıced by the thyroid gland. also produced, in smaller ınts, and is active at the lar level. For years it has been rking hypothesis among crinologists that T_4 is erted by the body to T_3. In this process, called ›dination," was demonstrated ·averman, Ingbar, and Sterling[2]. ›es convert to T_3, though the se quantities are still being ed.

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Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) In Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for **Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for **Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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WISCONSIN MEDICAL JOURNAL
Vol. 72, No. 1 JANUARY 1973

Medical
STATE MEDICAL SOCIETY OF WISCONSIN
GREEN SHEET

POLITICS

More Blessed To Give Than Receive?

Evidently believing that it is more blessed to give than to receive, Gov. Patrick Lucey gave Wisconsin a new leader for health on the same day he received the final report of his Health Task Force.

James R. Kimmey, MD, dynamic head of the American Public Health Association (APHA), was chosen by the Governor to fill the new post of executive director of the Health Policy and Program Council

JAMES R. KIMMEY, MD
Back to Wisconsin

(HPPC). The HPPC will be responsible for following through on the Task Force's recommendations.

Dr. Kimmey is expected to be on the job February first, six days after his 38th birthday. As APHA chief, the UW Medical School graduate had some pretty definite ideas about how to make areawide health planning really work. In his new job he will get a chance to test them.

The HPPC oversees the state's fledgling comprehensive health planning network along with four other federally funded programs: developmental disabilities, hospital construction, mental health centers' construction, and facilities for the mentally retarded.

In addition, the Task Force has proposed that HPPC be made the top health policymaking body in the state. This means everything from the medical schools and vocational schools to health related programs within such state departments as agriculture, public instruction, and health and social services.

The Governor said he would work with Dr. Kimmey "to implement recommendations of the Health Task Force that will improve the health care and delivery systems for our citizens."

Dr. Kimmey was APHA executive director for two and one-half years. Coincidentally or not, Gov. Lucey was the featured speaker at the November APHA annual meeting, shortly before Dr. Kimmey accepted the Wisconsin post. And, of course, the Governor's topic was the Health Task Force.

Dr. Kimmey left the APHA over disagreements with its executive board.

In his last editorial in *The Nation's Health,* APHA's official newspaper, Dr. Kimmey reflected a bit on his tumultuous two years as executive director. He had tried to make the organization a national leader aware of public needs and committed to action, he said. But, he said, "a funny thing happened on the way to national leadership. Although we gained 6,000 new members, we lost some 4,000 who were previously supporters of the Association."

continued on next page

An Invitation

All members of the Society are invited to come to meetings of reference committees of the House of Delegates at the 1973 Annual Meeting in March. Four committees will hear discussions of proposals for House action submitted by county medical societies and scientific sections of the State Medical Society.

Committee meetings will start at 7:00 pm Sunday, March 25, in Milwaukee's Pfister Hotel. Reference committees and their locations are:

RESOLUTIONS–AMENDMENTS
Imperial Ballroom

OFFICERS
Taft Room

*PLANNING
Roosevelt & Kennedy Rms

STANDING COMMITTEES
McKinley Room

FINANCE
Richard II Room

Proposals to be considered by each committee will be listed in the February GREEN SHEET along with summaries of resolutions submitted by January 25.

* NOTE: The Planning Committee, which has proposed a number of changes in the State Medical Society's Constitution and By-laws, also will hold open hearings from 2 to 4 pm on Monday, March 26, in the Empire Room.

MORE BLESSED *continued*

Those who have left APHA in the last two years had a number of reasons. Some objected to the (Kimmey-led) efforts at a broadened membership including students and laymen as well as professionals not previously involved in the group.

This included objections to 1972 sliding scale dues that charged only $5 to members earning less than $5,000 and $50 to those with incomes over $27,000. (This revealed that more APHA members than suspected made under $10,000, with severe ramifications for APHA revenues. Dues are now being revamped upward and dues categories are being consolidated.)

Other APHA members have quit over the group's new "action" program. This included such things as a successful suit against the Food and Drug Administration (FDA). In August, the U.S. District Court in Washington, D.C., agreed that the FDA allowed drug manufacturers too much time to prove their drugs were effective after adverse findings by the National Academy of Science–National Research Council.

Before coming to the APHA, Dr. Kimmey was the executive director of Community Health, Inc., a nonprofit, health-planning group in New York. Before that, he was the head of the Public Health Service's (PHS) Region II.

He joined the PHS after residency training in internal medicine. In April 1965 he became chief of the section, later known as the kidney disease control program. When he moved on to another assignment in 1966, the section's budget had increased a hundredfold and he received the PHS's commendation medal for his role in developing the program.

Three of his degrees are from the University of Wisconsin. He received a BS degree in Medical Science in 1957, an MS in Physiology in 1959, and an MD in 1961. He also holds a Masters Degree in Public Health from the University of California, Berkeley, which he received in 1967.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1973 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Carol Dovenport, Public Information Director, State Medical Society of Wisconsin.

MEDICAID

Kiddiecaid

Screening centers across the state are being readied for a new phase of Medicaid. Beginning next Spring, all Medicaid-eligible children under the age of 21 will be periodically screened to detect health problems.

Screening is expected to include vision, hearing and dental problems, growth and development, sickle cell trait, anemia, lead poisoning, completeness of immunizations, tuberculosis, diabetes and inspection for gross deformities.

It is expected that the screening will start in Milwaukee and move out to the rest of the state. However, Medicaid children do not have to wait for the state screening program to get to their area. They have the option of going to their physician to ask for it.

Information on tests and standards used in the screening and how to bill for doing it are expected to be ready soon from the State Department of Health and Social Services (DHSS).

Four Wisconsin physicians have been named to a ten-member state steering commission on the project. Two, MDs Edwin Larkin and William Buzogany, are in the State DHSS. The third, H. K. Tenney, III, MD, is medical director of the Bureau for Handicapped Children. The fourth is H. W. Carey, MD, Lancaster, who represents the State Medical Society.

Other members of the committee include representatives of optometric, dental and podiatry societies and Wisconsin associations for retarded children, mental health and prevention of blindness.

The screening program is in line with a 1971 directive from the US Department of Health, Education, and Welfare. This, in turn, was prompted by complaints that states have been ignoring the screening requirement, which was part of a Social Security amendment signed by then-President Lyndon B. Johnson on Jan. 2, 1967. A state law activating the program in Wisconsin was passed last March.

The screening centers will not provide treatment. Rather, they will refer patients for further diagnosis. The practitioner to whom the referral is made will be given the screening data and asked to file a report on diagnosis and treatment.

More information on the program is expected soon. Physicians interested in discussing the program are invited to contact the physician members of the steering committee.

PROJECT USA

Want to vacation in an exotic place? How about Island Pond, Vt.? Snow Shoe, Pa.? Or even such well known watering holes as Sacramento, Cal., Anchorage, Al., or Austin, Tex.?

These are a few of the 150 areas throughout the nation that will be looking for temporary MDs for a week or two. The AMA's PROJECT USA is working with the National Health Service Corps (NHSC) to find physicians to relieve the NHSC'ers who need a vacation or must leave briefly for other reasons.

NHSC physicians are located wherever there is a critical health manpower shortage. The areas are both rural and urban.

PROJECT USA is looking for any licensed MDs willing to spend some time in a new location. Particularly needed are physicians with family-care experience or interests. This includes primary-care physicians, internists, pediatricians, psychiatrists, and others who can provide general, continuing care.

For more information, write to PROJECT USA, Division of Medical Practice, AMA, 535 North Dearborn St., Chicago 60610.

TV

Price Is Wrong

"What Price Health?" asked NBC on its December 19 edition of NBC REPORTS. "What price fairness?" asked physicians across the country.

Medical societies, including Wisconsin's, peppered NBC and its affiliates with protests and demands for equal time following the special program which was highly critical of U.S. health care.

Robert Purtell, MD, Milwaukee, president of the State Medical Society, called it "an unfortunate mixture of fact and falsehood, as dangerous to the human mind as adulterated food is to the human body." He wrote to NBC, its five Wisconsin affiliates, the Federal Communications Commission, and Wisconsin's representatives in Congress.

"If you can't afford to live, you die," the program said, citing examples of people who were dunned mercilessly for medical bills. One woman who had three heart operations told how her hospital refused to let her in until she had paid on her past due bill.

The program cited such hackneyed statistics as the infant mortality figures, placing the U.S. 13th in the world. Physicians often protest use of such figures. The source (the *United Nations Demographic Yearbook*) states clearly that infant mortality statistics of different countries should not be compared because of the different standards of measurement involved.

Physicians point out that in the United States, for example, a baby is listed as a live birth if there is *any* sign of life, such as a heart beat in the umbilical cord. Some countries do not record a live birth unless the child takes a breath. Other countries do not list a live birth until the birth has been registered, and this can occur some days or even weeks after birth.

The program focused on such cases as that of Christy Knapp, a child who needed a heart operation but whose parents couldn't afford it because of the father's uncertain employment and accompanying insurance problems. Some 20,000,000 Americans are in the same boat, the program said, and implied that the only answer available is "if you can't afford to live, you die."

In his letter to NBC, Dr. Purtell pointed out that the State Medical Society has developed proposals for just such problems. One, for example, deals with the unemployed who are too poor to buy insurance and who aren't poor enough for Medicaid.

Dr. Purtell said, "If the public has a right to health care services, so it also has a right to balanced reporting and honest information about health care delivery."

The program hit other areas, such as the physician shortage and the problems of migrant workers, implying that some of it, at least, was the fault of the AMA.

Dr. Purtell said in his letter: "The real problems of poverty, poor education, unemployment, and unhealthy life styles were ignored in favor of a series of snide comments about the American Medical Association."

In a news release the day after the program, David J. Carlson, MD, president of The Medical Society of Milwaukee County, said the AMA, the county and the state medical societies "have aggressively supported legislation which would provide for not only catastrophic health insurance coverage but which would also eliminate the economic barriers which deny a significant portion of our population proper access to medical care because of financing problems."

He said all Americans share the burden for seeing that there is adequate funding for programs to alleviate the social and financial problems which cause ill health.

THE STATE MEDICAL SOCIETY OF WISCONSIN
330 EAST LAKESIDE STREET • P. O. BOX 1109 • MADISON, WISCONSIN 53701 • 608-257-6781

December 20, 1972

Mr. Julian Goodman, President
National Broadcasting Company
30 Rockefeller Plaza
New York, New York 10020

Dear Mr. Goodman:

The NBC program "What Price Health" aired last night (December 19, 1972) was an unfortunate mixture of fact and falsehood as dangerous to the human mind as adulterated food is to the human body.

The theme of this show, "if you can't afford to live, you die," is an appallingly false innuendo as to medical care in this country. That 5,000 communities have no doctors does not mean that their residents are without care. NBC certainly can do better than beat that hackneyed distortion of United States compared to foreign infant mortality rates. The real problems of poverty, poor education, unemployment, and unhealthy life styles were ignored in favor of a series of snide comments about the American Medical Association.

It is quite true that the economic burdens of health care are too often overwhelming for those millions of Americans who are unemployed, too poor to buy good insurance coverage and not poor enough to obtain Medicaid, and those who can't get adequate health insurance because they are self-employed. We in Wisconsin are doing something about these problems. The State Medical Society has developed proposals for insuring the "uninsurables" and the unemployed. We are supporting proposals to plug the loopholes in insurance that "surprise" those who think they have purchased comprehensive health insurance. Physicians and insurance companies are working in a dozen or more communities with innovative health maintenance programs providing almost total health care expense protection. We have joined with other professions and consumers in developing a health care review program to assure quality care for all people in this state at the most reasonable cost. Emergency medical programs are being developed to serve every corner of the state. New efforts are being made to find the most critical doctor shortage areas and to relieve them. A Governor's Health Care Task Force has added many new ideas to improve the already high level of health care in Wisconsin.

If the public has a right to health care services, so it also has a right to balanced reporting and honest information about health care delivery. We therefore respectfully request that NBC provide equal time under the fairness doctrine so that the people may know of the great progress being made toward solving America's health care problems and what they can do to help speed the achievement of the desired results.

We of the State Medical Society of Wisconsin offer our time and energies to help make such a program interesting, thoughtful and factual. We are certain other medical and professional societies throughout the nation would be happy to do the same.

Sincerely,

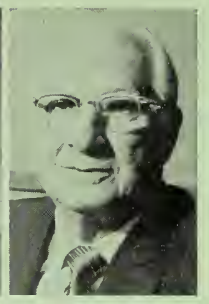
Robert F. Purtell, M.D.
President

RFP:jp

cc: Federal Communications Commission
Wisconsin Senators and Representatives
Local NBC outlets

LETTER TO NBC
"If you can't afford to live, you die."

DR. RUSSELL



DR. GALASINSKI

DR. KRISS

DR. RYAN

AMA

Tightening Up

Four Wisconsin physicians were recently reappointed to American Medical Association committees and councils. The announcements accompanied news of some of the most severe tightening of the national organization in its 125-year history.

Reappointed were:

- **Roman E. Galasinski, MD,** Milwaukee, who will head the Committee on Community Emergency Services.
- **Frederick C. Kriss, MD,** Madison, to the Committee on the Medical Aspects of Sports.
- **James C. H. Russell, MD,** Fort Atkinson, and **Allan J. Ryan, MD,** Madison, both to the Committee on Exercise and Physical Fitness.

Five years is now the maximum tenure on these and all other AMA committees under the new rules.

Most notable among AMA cutbacks was the abolishing of six committees and four councils. No longer in existence are: the 12-member Council on Drugs; the 10-member Council on Occupational Health and its three committees with a total of 18 members; the 7-member Council on Voluntary Health Agencies and a component 7-member committee; the 11-member Council on National Security; the 15-member Committee on Medicine and Religion; and the 6-member Committee on Medical Aspects of Automotive Safety.

In addition, the name of the Council on Environmental and Public Health was changed to Environmental, Occupational and Public Health, and a member specializing in occupational medicine was to be added.

A spokesman for the AMA Board of Trustees said dropping the councils and committees does not mean those areas of concern are being abandoned. Rather, emphasis is being shifted and programs combined.

This move is expected to save the AMA $840,000. The savings will be increased to more than $1 million this year with AMA staff reductions, fewer meetings by remaining councils and committees, fewer members in the committee structure, scrapping of AMA institutional advertising, and charging members for subscriptions to all specialty journals.

The actions came on the heels of proliferating expenses which have outstripped the AMA's declining revenues from membership and advertising.

SMS *Hot Line*

NO OPTOMETRY SCHOOL is needed in Wisconsin, according to the Optometry Committee of the Wisconsin Regional Medical Program. The Committee suggested that the UW Extension develop a continuing education program for optometrists to give them "an opportunity to improve their ability to recognize conditions that require medical care." It also said a joint committee of ophthalmologists and optometrists should be established to study long range needs. UW President John Weaver asked for the report.

NICARAGUA'S NEEDS for medical help following last month's earthquake have been met by an overwhelming response from Wisconsin physicians. According to Nicaragua's Minister of Health, the first 48 hours after the quake were the worst and now the crisis has passed. Speculation is that there may be a need for some specialists or subspecialists next summer but not until then. State Medical Society is keeping list of well over 150 Wisconsin physicians who volunteered their services in response to a letter from President Robert Purtell, MD.

WPS®

report

for Wisconsin Physicians

Volume I Number 1 January 1973

Did you know?

WPS provides payment for surgical-medical benefits on a **customary, usual and reasonable** basis. In determining customary, usual and reasonable fee guides, we rely upon advice furnished to us by your county medical society and/or the State Medical Society's Insurance Advisory Committee.

When a claim report is received in our office, we refer to local guidelines to determine if the fee is acceptable. In most instances, the claim is approved for payment as charged. If the fee exceeds the level of charges established by the local committee, WPS does one of two things:

contact the attending physician and inform him of the guidelines established in his community and ask for additional information or,

depending upon the circumstances of the case, it may be referred directly to the advisory committee.

When a case is referred to the advisory committee it includes a summary of all relevant information, but it excludes the name of the patient and physician. A copy of the summary is sent to the physician to notify him that the case is being referred to the advisory committee. No case is referred to the committee before giving the attending physician the opportunity to review the case and make additional comments.

Sometimes the attending physician is asked to be present at the advisory committee meeting in order to discuss the case. After the review, the attending physician is sent the committee's recommendation. If he disagrees with the committee's action, the case goes back to the committee with his additional comments. Nearly 100% of all disagreements are settled through this process. Several disputes each year are given further individual attention.

We at WPS feel that this is the most equitable approach to adjudicating fee questions. The process is "grass roots" peer review with the local physicians' society establishing the fee guidelines and reviewing the claims when the fee guide is exceeded.

WPS Service for You

WPS processes 65,000 claims per month. We also respond to 6,000 inquiries, written and phone, each month. In processing claims, as well as in responding to inquiries, we feel that "service" is of primary importance. We owe it to both subscribers and physicians, not only to process claims promptly and accurately, but also to respond to inquiries immediately.

In addition to answering correspondence, we are continuously monitoring letters and phone calls in order to determine why an individual might have to contact us. This has helped us to "clean up" our forms, and thus reduce claims correspondence. Ideally WPS wants to reach the point where both the subscriber and the provider understand perfectly a WPS claim action.

Report is New

This is the first *WPS Report for Wisconsin Physicians.* The *Report* is a bimonthly service to physicians and their medical assistants. It is perforated and punched so that it may be torn out and kept in a three-ring binder for future reference. News for physicians appears on the front page and tips for your medical assistant in processing claims are on the back page. We invite your comments, just write: *WPS Report for Wisconsin Physicians,* Box 1109, 330 E. Lakeside St., Madison, Wisconsin 53701.

and their Medical Assistants

TIPS for Medical Assistants

"Tips" to make paperwork easier for medical assistants will be listed on this page of Report in each bimonthly issue. Observing these guidelines will help assure that your WPS claims are processed promptly.

- Many WPS health insurance policies cover **dependent students** over age 19. If you have a claim for a dependent over age 19, please indicate on the claim report whether or not the patient is a full-time student.

- The fee WPS pays a surgeon for an operative procedure includes **postoperative care**. We would not routinely allow a second physician to bill for postoperative inhospital medical care. Consideration can be given for allowing medical care if the second physician is treating a separate medical problem. It helps, therefore, if you indicate the medical problem being treated when a physician bills for postoperative care on a surgical case.

- When a **complicated or unusual surgical procedure** is performed, it would help us if you would submit a copy of the operative report along with the claim. This will save time in processing the claim as we will not have to stop to write for the report. The operative report is needed primarily when the physician is charging higher that the usual fee due to complications or in cases involving bilateral or multiple surgical procedures.

- If you are aware that other physicians were also involved in treatment during the **hospital confinement**, please indicate their names in the appropriate section on the WPS Claim Report. This will enable us to obtain the other physician's claim report to determine whether or not concurrent medical care is involved in treatment of a single medical problem.

- When lesions or warts, or a significant size, are excised please tell us as explicitly as possible, their location. size and number.

Still Speeding Up Claim Processing

WPS Claims Department now has direct access into the computer for on-the-spot coverage information for all subscribers.

The process is called the Medex Inquiry System and it means that a claim can be processed as soon as it reaches the Claims Department. Or when you telephone us with a question, just give us the subscribers number, then we push the proper button and have your answer in two seconds.

The answer comes onto the screen of the CRT (cathode ray terminal shown here) and our representative tells it to you. No more putting you on "hold" or calling back later. You have the information you need and our gal is ready for another call.

In the foreseeable future, the claims adjusters will be able to directly enter the claims information into the computer right from his desk. This will further decrease our claims processing time even though we are already processing claims and mailing benefits within, on an average, 13 working days.

Bill Schweers, Claims Manager, sees the correct information on the CRT just two seconds after the proper button is pushed.

WPS

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in two categories: PHYSICIANS EXCHANGE and COMMERCIAL. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. DISPLAY RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701; or phone (area code 608) 257–6781.

PHYSICIANS EXCHANGE

INTERNIST WANTED: POSITION available to join young expanding all specialty group in Green Bay, Wis. New clinic, ideally situated, staff privileges in three hospitals. Excellent school and recreational facilities. Salary one year then partnership available. Contact Dept. 381 in care of the Journal. 11–1

IMMEDIATE OPENING FOR AN ophthalmologist, family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write S. R. Lee, MD, President, or Russel Peterson, Clinic Mgr., P.O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 11tfn

WANTED: GENERAL PRACTITIONER to join 3 young general practitioners in college community in southeastern Wisconsin. Two hospitals with 650 beds. Starting salary with progression to full partnership, vacation, sick leave, and profit-sharing benefits. Contact Dept. 374 in care of the Journal. 7tfn

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living. DISCOVER WATERTOWN, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy-going pace of a residential city.

WE URGENTLY NEED Family Practitioners, Internists, and other specialists to join existing medical staff. An immediate successful practice assured.

Our new Community Health Care Center with its beautiful 110-bed General Hospital, connecting (but separate) 24-Unit Medical–Dental Office Building, and connecting 130-bed Nursing Home, was completed last year.

Watertown, a progressive community, is ideally located equidistant between Milwaukee and Madison in southeastern Wisconsin's lake district. The community has a trade and medical practice area serving 50,000 people. Many new schools, parks, trees, social and recreational facilities. A stable economy.

Excellent rapport with the University of Wisconsin Medical School in Madison and the Medical College of Wisconsin (formerly Marquette University School of Medicine) in Milwaukee. Medical Staff leading and supporting recruitment effort. Write or call E. A. Miller, MD, Chief of Medical Staff, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel. 414/261–4210. 5tfn

MULTISPECIALTY CLINIC IN northeastern Wisconsin is expanding; group seeking allergists, general surgeon, and internist. Ultramodern 500-bed hospital located close to the clinic. Excellent recreational area. Salary first year, corporate member thereafter. Small investment second year into corporation. Young group, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 378 in care of the Journal. 9tfn

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. General Practice
3. Internal Medicine
4. Obstetrics–Gynecology
5. Orthopedics

This is an opportunity to join a 27-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 10–3

GENERAL PRACTICE. LIVE AND work in northwestern Wisconsin vacationland. Corporate general practice expanding to 8. If interested, call or write: F. M. Bannister, MD, Chetek, Wis. 54728; tel. 715/924–4811. 12–1

WANTED: GENERAL PRACTITIONER to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

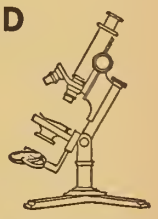
THE OSHKOSH CLINIC IS SEEKing associates in the following areas:

1. Allergy
2. General Practice
3. General Surgeon
4. Internal Medicine
5. Dermatology

This is an opportunity to join a 14-man Wisconsin group located in college community of over 60,000 with excellent hospital facilities. Summer and winter recreation unlimited. For further information, contact B. Greenwood, MD, Oshkosh Clinic, Oshkosh, Wis. 54901. p1/tfn/73

WANTED EMERGENCY ROOM physician for daytime coverage, Monday through Friday. Excellent salary, one month paid vacation to join 11-man emergency room corporate group. City of 60,000 with excellent schools, living conditions, and recreation. Contact Community Emergency Services, S.C., P. O. Box 2022, Appleton, Wis. 54911. 1–3/73

AUTHORIZED REPAIR SERVICE



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Complete rebuilding
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(We are interested in any microscopes of any age—whole or in parts)

DAVIS INSTRUMENT CO., INC. ROUTE 2
Marshall, Wis. 53559
Tel. (414) 655–3211

WANTED: GENERAL PRACTITIONER, preferably of Spanish extraction, with good command of the Spanish language, to associate with 4-man general practitioner group in fast growing city of 40,000. Salary open, 450-bed hospital. Contact by letter or tel: J. L. Nolan, MD, % Waukesha Medical Clinic, S.C., 237 Wisconsin Ave., Waukesha, Wis. 53186. Tel. 414/542–8150 (unlisted number). 12tfn

PHYSICIANS NEEDED: MULTI-specialty group of 23 specialists needs an:

1. Orthopedist
2. Otolaryngologist
3. General Practitioner

Attractive income arrangements, association membership within 1 year, pension, and fringe benefits. Excellent community of 50,000. Contact R. B. Windsor, MD, 1011 N. 8th St., Sheboygan, Wis. 53081. Tel: 414/457–4461. 1/73tfn

WANTED: INTERNIST, GP TO join expanding mixed specialty group in Green Bay. New clinic building and excellent hospital facilities. Contact R. J. Murphy, MD, Deckner Medical Center, 1751 Deckner Ave., Green Bay, Wis. Tel: 414/435–8301. p9/tfn

WANTED: OPHTHALMOLOGIST. Practice solo. Semi-retiring. Large practice. Excellent location. City needs 2 ophthalmologists. Contact Dept. 380 in care of the Journal. 11–1

WILKINSON CLINIC, OCONOMOWOC, Wis., an incorporated group of 11 physicians, with various specialties and general practice represented desires, as associates, general practitioners, internists or pediatricians. Located 25 miles west of Milwaukee, surrounded by lakes, with excellent schools and recreational facilities. 110-bed accredited hospital, with full time pathologist, radiologist, physical therapy services, located 200 yards from 8 year old clinic. Call schedules adjusted with free time and coverage available. Salary open and corporate status after one year. Relocation expenses provided—profit sharing and retirement income plan. For further information please write: Business Manager, Wilkinson Clinic, Oconomowoc, Wis. 53066 or tel: 414/567–4433. 2tfn

WANTED—GENERAL OR FAMILY practitioner to join 3-man group. 45-bed hospital in community. 35 miles from St. Paul. Baldwin Clinic, S.C., Baldwin, Wis. 54002. Tel: 715/684–3326. 10–5

PLANT MEDICAL DIRECTOR

Immediate opening for licensed physician to supervise Medical Department and participate in plant occupational health program.

Attractive salary, liberal benefits including use of staff automobile. Interested parties should send resume in confidence to:

G.M. ASSEMBLY DIVISION
General Motors Corp.
Janesville, Wisconsin 53545
Attn: B. M. Buckley,
Personnel Director

An Equal Opportunity Employer
1–2

INTERNIST OR GP: COUNTY Mental Hospital awakening to its role as comprehensive mental health center needs physician to enlarge and implement the development of a program to meet the medical care aspects of total treatment program. Modern Medicare-certified extended care facility part of complex. New 292-bed mental hospital under construction, scheduled for spring completion, includes abundant space for medical clinic. Staff membership at community general hospital encouraged. Progressive city of 50,000 gateway to Northwoods, excellent schools, outstanding parks, expressway access to Madison (45 minutes), Milwaukee (80 minutes), and Chicago (90 minutes). Excellent opportunity to meet challenge at your own pace with minimum of pressure. Salary $27,000, liberal fringe benefits. Administrator, Rock County Hospital, Box 351, Janesville, Wis. 53545. 2tfn

IMMEDIATE OPENING FOR OB-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-physician, multi-specialty group. Excellent group benefits: Pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young physician with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Ave., Manitowoc, Wis. 54220. 9/72tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

WANTED: GENERAL PRACTITIONER, preferably with surgical and obstetrical experience. Ready made practice. No investment. Senior partner retiring. Junior partner desires associate. Ideal midwest college town for family. All educational, recreational, religious, medical and dental facilities readily available in community. Contact Dept. 370 in care of the Journal. 5tfn

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

IMMEDIATE OPENING FOR IN ternist or General Practitioner to jo established practice. Brand new clin building and adequate hospital facilitie Good starting salary with partnersh following year. Contact Dept. 363 care of the Journal. 10tf

WANTED: INTERNIST—BOAR qualified—for two internists and two su geons group in Iowa; own building; larg modern hospital; Midwest shopping an medical center; 30,000; well balance economy; two hours to three large citie lake resort 10 miles away; hunting an fishing area; skiing two hours away; ex cellent school system; junior college; a gallery; superb library facilities. Salar ($35,000–$40,000) depending on qualif cations. Early partnership. Contact Dep 384 in care of the Journal. 1/7

THE MARSHFIELD CLINIC I seeking additional specialists in man areas. This opportunity combines a busy stimulating referral practice plus an ac tive local practice with an opportunit for family medicine. We provide exce lent salary and fringe benefits as well a opportunities for research and teaching Excellent retirement program and insu ance plan. Modern 7-story office buildin with all diagnostic facilities available Excellent 400-bed hospital. We are look ing for physicians in the followin specialties:

1. Internal Medicine
2. Orthopedic Surgery
3. Rheumatology
4. Family Medicine
5. Plastic Surgery
6. Child Psychiatry
7. General Surgery
8. Ophthalmology
9. General Practice
10. Pulmonary Disease

For further information, please contac Russell F. Lewis, MD, Medical Director Marshfield Clinic, Marshfield, Wis. 11, 1, 3,

PHYSICIAN POSITION AVAILA ble: Student Health Center, Universit of Wisconsin–La Crosse. Excellen physical plant with attached Departmen of Physical Therapy and certified labo ratory. Competitive salary with adequat vacation time and fringe benefits. Equa opportunity employer. Phone, visit o write: Lou R. Schmidt, MD, Studen Health Center, University of Wisconsin-La Crosse, La Crosse, Wis. 54601. Tel 608/785–1800, Ext, 226 or 274. 1–3/7

THE PEMBER–NUZUM CLINIC 17-man multi-specialty group, seekin specialists in Internal Medicine. Pediat rics, and Ophthalmology. Excellent re tirement and insurance plans. Write o call collect: P. Richard Sholl, MD, Bo 551, Janesville, Wis. 53545; tel: 1–608 752–7811. 4tf

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing health, disability and liability insurance Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tf

GP WANTED WITH INTEREST IN abdominal surgery to replace member of 4-man group, well equipped clinic, associated with new hospital, in the heart of Kettle Moraine area, 45 minutes from Milwaukee. Salary open, no investment needed. Call collect 414/893–1411, L. J. Steffan, MD. p11–2

WANTED: FAMILY PRACTITIONERS and internists to join 20-man mixed specialty clinic. Teaching opportunities guaranteed. Salary with corporate ownership in two years. William Rock, MD, East Madison Clinic, 1912 Atwood Ave., Madison, Wis. 53704. 6–5

IMMEDIATE OPENING FOR ONE or two general practitioners to join an established small Green Bay group. First year salary, $25,000 or commensurate with training and experience, partnership available. Contact Dept. 367 in care of the Journal. 2tfn

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

LARGE PRACTICE AVAILABLE (for sale or rental arrangements) in Ripon, an attractive and comfortable little city. Recently deceased physician's office only three years old—specifically built for two or three doctors. His widow and partner, A. C. Bachus, MD, are very anxious to obtain another physician. Community very anxious, too. Rental arrangements considered reasonable. Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g10tfn

THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine—multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Neurology
2. Orthopedic surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Emergency Room

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 1–3/73

TWO EMERGENCY ROOM PHYsicians. New group forming to serve 350-bed modern hospital. Seven well equipped emergency rooms. Full specialty back-up and referrals. Opportunity to set up own working conditions. No paper work. Located in a medium-sized midwest city of 60,000. Excellent recreational areas and good living conditions. Contact Sister Mary Gregory, Admin., St. Francis Hospital, La Crosse, Wis. 54601. 10tfn

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

COMMERCIAL

FOR SALE: PICKER 100 MA-100 X-ray unit complete with horizontal Bucky table, $500 including chest changer. Contact J. J. McDuffie, MD, 3660 North Teutonia Ave., Milwaukee, Wis. 53216. Tel: 414/442–5033. 1/73

FOR RENT: OFFICE SPACE IN Waunakee, 1200 sq. ft., new dental building. Ten minutes from Madison. Contact S. A. Karls, DDS, 400 2nd St., Waunakee, Wis. 53597. Tel: 608/849–4199. 10tfn

MEDICAL OFFICE NOW AVAILable. Eleven hundred sq. ft. ground floor, individual controlled heating and air conditioning, paved parking lot. 1925 Washington Ave., Racine, Wis. 53403. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634–6833. 10tfn

WANTED TO BUY: USED MEDIcal office equipment such as examining tables, chairs, filing cabinets, etc. Contact or write: Walworth Medical Group, Walworth, Wis. 53184; tel. 414/275–2101. 12–1

FOR LEASE. SHEBOYGAN, WIS. Suite, at present occupied by oral surgeon. Available May 1, probably earlier. Other occupants are a physician and dentist. Suitable for any medical or dental specialty. Later purchase of building possible. For details write to Dept. 383 in care of the Journal. 1tfn/73

MILWAUKEE GENERAL FAMILY practice. Grossing $90,000 on 4 day week. Much greater potential. Attractive medical building included in this sale. Excellent opportunity for group or individual. PROFESSIONAL PRACTICE SALES, 540 Frontage Rd., Northfield, Ill. 60093. Tel: 312/441–6111. p1/73

PRACTICE FOR SALE: FAMILY practice in Central Wisconsin city of 1600, in resort area of 10,000. Practice established 45 years. Gross about $60,000. Wish to retire at age 74. Easy driving distance to three hospitals. Excellent office. Good hunting and fishing. Sale for equipment and stock of medicines. Tel: 414/295–3118. 11–1

FOR SALE: BY ILLNESS DISabled physician and surgeon, as a complete unit for clinic or other MDs. Appraised by expert in new and used equipment, at minimum appraisal. All office furniture is of hand finished and rubbed, light walnut. Items: 2 exam and treatment tables, 2 stools, 1 instrument cabinet, 1 treatment stand, 1 exam chair, 1 treatment cabinet with drawers and doors (must be seen to appreciate), 1 sterilizer, 2 head lamps, 1 National procto set, transformer for lights and cautery to accommodate other instruments; 1 Raytheon microtherm, 1 Micro hematocrit, 1 centrifuge, many useful instruments, 1 baby scale, 1 adult scale, 1 Luxo floor light, 1 Miller electro unit, 1 Welch Allen oto & ophthalmoscope, 4 ear syringes—different abilities, 1 General Electric E.C.G. button type, 1 Kidde dry ice, plus sundries useful to the practice of medicine. Below the appraised evaluation, I will take $1500.00 firm. X-ray separate from above articles, 1 General Electric diagnostic table model 39, hand manipulated with all necessary accessories, speed screens, paper holders, some fresh film, hangers, stainless steel tank, etc. $500.00 firm. Call, write, or see: Glenn R. Stauff, MD, 2323 S. Webster Ave., Green Bay, Wis. 54301. Tel: 414/437–3890. 9tfn

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

FOR SALE: PROFEXRAY MAchine. Model TS 2, maximum—KVP 100, MA—10. Contact Mrs. B. J. Haines, Cadott, Wis. 54727. g5tfn

ATHENS GENERAL PRACTICE IN modern professional building. Grossing $85,000, netting $60,000. Can be purchased on a lease arrangement with no money down. Wonderful opportunity. PROFESSIONAL PRACTICE SALES, 540 Frontage Rd., Northfield, Ill. 60093. Tel: 312/441–6111. p1/73

COMING TO MADISON?

Hospital Hotel

Randall Tower

Outpatients
Patient Visitors
Medical Personnel

One block from
University Hospitals

1314 West Johnson St.
Madison
Ph. 608/256–3166

1–2/73

PUBLICATIONS

Medical Advice for the Traveler. It has become increasingly important for every traveler, whether planning two weeks in Europe, two months in a more exotic spot, or actual residence abroad, to know and understand the medical challenges he may face. In this concise and informative guide, Kevin M. Cahill, MD, whose major professional interest has long been the medical needs of the traveler, provides a common-sense approach to such subjects as motion sickness . . . the time-zone syndrome . . . dietary concerns in foreign lands . . . inoculations that should be taken before the trip . . . a complete medical kit that every traveler should carry with him . . . what to do should illness occur during the trip . . . and the proper medical steps to take when the traveler returns home. Price: 95¢. Available from Popular Library, 355 Lexington Ave., New York, N.Y. 10017.

The Medical and Healthcare Stock Market Guide. 1972–73 Edition. Adeline B. Hale and Arthur B. Hale, editors. A valuable aid in keeping track of profitable medical and healthcare investment opportunities during the seventies. Edited for both the seasoned investor and neophyte alike, this new guide focuses on over 700 publicly-traded firms that inhabit an exciting and dynamic marketplace. Its 400 pages contain the vital and essential facts about companies that produce and sell pharmaceuticals, medical equipment, blood testing instrumentation, optical, dental and cardiac prosthetics, hospital supplies, and multiphasic health testing hardware. In addition, there are descriptions of firms that provide lab testing services, medical data processing, hospital and convalescent care, as well as others who provide the tools for biomedical research. Published by International Bio-Medical Information Service, Inc., Box 707, Arcadia, Calif. $32. (Overseas postage, add $6). California residents add 5% state sales tax. 1/73

Human Aging II: An Eleven-Year Followup Biomedical and Behavioral Study, prepared by HEW's National Institute of Mental Health, analyzes survival among healthy elderly men, and considers various medical and psychiatric aspects and social adaptation of the aging. The NIMH began to explore and define normal human aging in 1955 with the study of a group of healthy male subjects with an average age of 71. The results of that initial investigation were described and discussed in 1963 in the volume *Human Aging: A Biological and Behavioral Study.*

The followup study, carried out during 1967–68 at the Philadelphia Geriatric Center in Philadelphia, involved the same group. A careful effort was made to replicate the original procedures.

Dr. Thomas E. Anderson, Chief of the Section on Aging at NIMH, said the second volume contains data on the long-term effects of aging on biological and behaviorial functions and clarifies the interrelationships among these functions with respect to aging. The report relates physical and behavioral factors to later developments in old age, survival or death. It describes how both physically healthy and unhealthy individuals adapt to aging and discusses how the aged view themselves, the environment, and relate to time.

Copies of *Human Aging II: An Eleven-Year Followup Biomedical and Behavioral Study* (DHEW Publication No. (HSM) 71–9037) and *Human Aging: A Biological and Behavioral Study* (DHEW Publication No. (HSM) 71–9051) are available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. Price: $1.25 and $2.50 respectively.

Current Clinical Studies and Patient Referral Procedures, The Clinical Center, National Institutes of Health, DHEW Publication No. (NIH) 72–217; Revised August 1972, Bethesda, MD. 20014. Procedure for referral of patients, eligibility requirements, length of patient stay, and clinical studies in: allergy and infectious diseases, arthritis, metabolism, and digestive diseases; cancer; child health; dental; eye disorders; heart and lung diseases; mental health; and neurological diseases.

Group Practice: Guidelines to Joining or Forming a Medical Group. Available at no charge from the American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610; the Medical Group Management Association, 956 Metropolitan Bldg., Denver, Colo. 80202; or the American Association of Medical Clinics, P. O. Box 949, Alexandria, Va. 22313.

ANNOUNCEMENTS

CURRENT PERINATAL INFORMATION IN DIAL ACCESS LIBRARY. The Wisconsin Dial Access Tape Library is a source of immediate practical information for doctors and nurses providing perinatal care. Over 40 tapes are now available dealing with such problems as abruptio placenta, bacteremic shock, respiratory distress syndrome, hypoglycemia of the newborn, etc. Tapes are continually revised by the authors. This service is available to physicians for a $25 subscription fee. Nurses can utilize this service free of charge. For further information and a complete list of dial access tapes write: Dial Access Library, 610 North Walnut Street, Madison, Wis. 53706.

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20–21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

ORDERS for Emeritus Dean Willia S. Middleton's new book, "Tangible a Intangible Values in Modern Medicine are now being accepted by the Wisco sin Medical Alumni Association offic The 300-page book contains a collectic of Doctor Middleton's 35 best no clinical writings — articles and speech that he has presented to medical and l audiences over the past several decade Cost: $11.50. Contact Mrs. Froland the Medical Alumni office, 610 N. Wa nut, Madison. Tel. 608/263–4914.

BEGINNING JANUARY 1973, ce tain dependent grandchildren may qua ify for social security benefits on th record of a retired, deceased or disable grandparent.

FILMS

The Treatment of Acute Drug Ove dosage, an educational film directed t those medical, paramedical, and law enforcement personnel who have firs contact with a victim of drug overdos is available on loan from Eli Lilly an Company. The 33-minute film explain emergency treatment for acute ove dosage of heroin, amphetamines, ba bituates, and hallucinogens. It illustrate the methods of maintaining airway, res piration, and cardiovascular support an the use of pharmacologic agents in th treatment of overdose. The film was pro duced at the Haight–Ashbury Free Med ical Clinic in San Francisco. Loan re quests should be sent to Eli Lilly an Company, Film Library, Indianapolis Indiana 46206. Three preferences fo showing dates should be indicated. Th movie also may be purchased for $130

Before the Emergency. An estimate 45,000 accident victims die or are per manently disabled each year. The rea sons and efforts undertaken to preven these tragedies are dramatically explore in a 16mm-sound and color film titled "Before the Emergency."

This 28-minute film is available or free-loan to colleges, church and com munity groups throughout the country from Modern Talking Picture Service.

The tragic story of inadequate care and treatment of people hurt in high way, home and occupational accidents, due to the lack of proper equipment in ambulances, lack of thorough education and training of crews and lack of radio communications between ambulances and hospitals is the theme of this motion picture.

A program of recommended community action, such as that adopted by a resort city in Wisconsin (Minocqua) is also detailed.

This impotrant public service documentary, sponsored by the Employers Insurance of Wausau, should be seen by every adult in America.

Requests for playdates for "Before the Emergency" should be sent to Modern Talking Picture Service, 2323 New Hyde Park Road, New Hyde Park, N.Y. 11040.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Feb. 1–4: Third Annual Winter Refresher Course for Family Physicians, Medical College of Wisconsin and Wisconsin Academy of Family Physicians and its Milwaukee Chapter, Pfister Hotel, Milwaukee. Info: Mrs. Elaine Gamerdinger, Continuing Education Department, MCW, 561 North 15th St., Milwaukee, Wis. 53233; tel. 414/272–5450, ext. 320.

Feb. 3: Symposium on "Recent Advances in Gastrointestinal Endoscopy," Medical College of Wisconsin's Office of Continuing Education, Wingspread Conference Center, Racine. Info: Joseph E. Geenen, MD, Course Director, Department of Medicine, MCW, 8700 West Wisconsin Ave., Milwaukee.

Feb. 13–15: Tenth Annual Telemark Symposium and Ski-Outing, Indianhead Chapter, Wisconsin Academy of Family Physicians, Mt. Telemark near Cable.

Feb. 15: State Medical Society In-Depth Teaching Program, Madison General Hospital, Madison.

Feb. 28: Professional section meeting of Wisconsin Diabetes Association, at headquarters of Northwestern Mutual Life Insurance Company in Milwaukee. Info: WDA, 225 East Michigan Ave., Milwaukee 53202.

Mar. 18–20: Annual Meeting, Wisconsin Association for Perinatal Care, Pioneer Inn, Oshkosh. Info: Perinatal Secretary, Hartford Labs, St. Mary's Hospital Medical Center, 720 S. Brooks St., Madison 53715.

Mar. 24: Annual Banquet, Marquette–MCW Medical Alumni Association, Milwaukee Athletic Club, Milwaukee. Reservations: M–MCW Medical Alumni Assoc., 561 N. 15th St., Milwaukee 53233; tel. 414/272–5450, ext. 250.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Mar. 26–27: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

Mar. 27: Spring Meeting, Wisconsin Surgical Society, Milwaukee.

Mar. 29–31: Midwest Regional Medical Symposium (Exercise and The Heart) and Physical Fitness Clinic, at University of Wisconsin–La Crosse. Info: Dr. Clifton De Voll, Assoc. Dean of HPER, UW—La Crosse, La Crosse 54601.

Apr.: Spring Meeting, North Central Wisconsin Orthopedic Society, Wausau. Info: Thomas O. Miller, MD, President, 630 First St., Wausau 54401.

Apr. 11: Family Practice Conference, Neenah.

Apr. 12: Family Practice Conference, Wausau.

Apr. 18: Family Practice Conference, Eau Claire.

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May: Annual Meeting, Wisconsin Clinic Managers. (Note that this will not be held in conjunction with the Annual Meeting of the State Medical Society as in past years.)

May 4: Spring Conference, Wisconsin Association of Alcohol and Other Drug Abuse, Howard Johnson Motel, Fond du Lac.

May 9: Family Practice Conference, Neenah.

May 10: Family Practice Conference, Wausau.

May 16: Family Practice Conference, Eau Claire.

May 30–31: Symposium on Peptide Synthesis, at The Wisconsin Center on the University of Wisconsin–Madison Campus, Madison. Info: Theo Gerritsen, DSc, Postgraduate Medical Education, WARF Bldg., 610 Walnut St., Madison 53706.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

1973 NEIGHBORING STATES

Feb. 7–9: Nuclear Medicine Conference, Hackley Hospital and the Central Chapter of the Society of Nuclear Medicine, Petoskey, Mich. Info: James C. Carlson, MS, Radiological Physics, Hackley Hospital, 1700 Clinton St., Muskegon, Mich.

Feb. 13–16: Four-day "Refresher Course for the Family Physician," University of Iowa Memorial Union, Iowa City, Ia.

Feb. 22–24: 16th Congress on Administration, American College of Hospital Administrators, The Palmer House, Chicago, Ill.

Mar. 5–10: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, Chicago. 1855 West Taylor St., Chicago, Ill. 60612.

Mar. 25–28: Chicago Medical Society's Midwest Clinical Conference and the Illinois State Medical Society Annual Meeting, Conrad Hilton Hotel, Chicago, Ill.

Mar. 26–29: Continuing education course in Neurotology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, 1855 West Taylor St., Chicago, Ill. 60612.

Apr. 16–18: Third Annual Great Lakes Health Congress, McCormick Place-on-the-Lake, Chicago, Ill.

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

June 10–15: 1973—Midwest Institute on Alcoholism, Western Michgian University, Kalamazoo, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Feb. 21–24: Surgery of the Hand, University of Colorado School of Medicine, Office of Continuing Medical Education, 4200 East Ninth Ave., Denver, Colo. 80220.

Feb. 25–Mar. 3: *Continuing Education for Excellence in Medicine and Surgery.* Annual Meeting of the American Society of Contemporary Medicine and Surgery. Fountainbleau Hotel, Miami Beach, Fla. Info: Miss Virginia Kendall, 30 N. Michigan Ave., Rm. 1629, Chicago, Ill. 60602.

Mar. 10–11: Provocative Allergy Course, Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. Info: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609.

Mar. 15–16: 22nd Annual Postgraduate Course in Pediatrics of The University of Texas Medical Branch, Galveston, Tex. Info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Tex Medical Branch, Galveston, Tex. 77550.

Mar. 19–22: Symposium on "Controversial Issues in Pediatric Cardiology, 1973," University of Miami School of Medicine, Division of Pediatric Cardiology, at Sonesta Beach Hotel, Key Biscayne, Fla.

Mar. 19–22: Annual Meeting, New Orleans Graduate Medical Assembly, at Fairmont Roosevelt Hotel, New Orleans, La.

MEDICAL MEETINGS . . .

Mar. 21–24: Postgraduate Seminar on "Emergency Medicine" Florida Chapter, American College of Emergency Physicians, at Playboy Plaza Hotel, Miami Beach, Fla.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

Apr. 11–13: Annual Meeting and National Conference, National Society for the Prevention of Blindness, Inc., at Hotel Roosevelt, New York City.

Apr. 16–19: American Industrial Health Conference, Currigan Hall, Denver, Colo. Info: Industrial Health Conference, 150 North Wacker Drive, Chicago, Ill. 60606.

Apr. 26–28: Fourth National Congress on Medical Ethics, Washington Hilton, Washington, D.C.

May 4–5: Annual Conference, British Columbia Oto-Ophthalmological Society, Hotel Vancouver, Vancouver, B.C.

May 20–25: Hospital Medical Staff Conference, Sun Valley, Idaho. Info: Northwest Hospitals Education and Research Alliance, % Oregon Association of Hospitals, 220 S.W. Morrison St., Portland, Ore. 97204; tel. 503/228–5608.

May 20–26: American Gastroenterological Association postgraduate course, *Cirrhosis and Portal Hypertension* as part of Digestive Disease Week. Americana Hotel, New York. Info: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N. J. 08086.

May 29–31: Postgraduate seminar *Master Interpretation of Clinical Electrophysiology* sponsored by University of Miami School of Medicine and Council on Clinical Cardiology of the American Heart Association. Contemporary Hotel at Disney World, Lake Buena Vista, Fla. Info: Dr. Louis Lemberg, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

June 14: Eighth Annual Continuation Course on "Clinical Electroencephalography," Statler–Hilton Hotel, Boston, Mass. Info: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55901.

June 15–16: Annual Meeting, American Electroencephalographic Society, Statler–Hilton Hotel, Boston, Mass. Info: Mrs. Margaret H. Henry, Exec. Secy., American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

1973 AMA

Feb. 9–11: Congress on Medical Education, Palmer House, Chicago.

Mar. 7–10: Quality of Life Congress, Palmer House, Chicago.

Mar. 22–25: Medicolegal Symposium, Hilton International Hotel, Las Vegas.

Mar. 29–30: 26th National Conference on Rural Health, Statler Hilton Hotel, Dallas.

Apr. 6–7: 19th Annual Conference of State Mental Health Representatives, Drake Hotel, Chicago.

Apr. 13–14: 7th National Congress on the Socio-Economics of Health Care, Marriott Motor Hotel, Chicago.

Apr. 26–28: 4th National Congress on Medical Ethics, Washington–Hilton Hotel, Washington, D.C.

Apr. 30–May 1: Congress on Environmental and Public Health, Drake Hotel, Chicago.

June 24–28: Annual Convention, New York.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

* * *

Professional section of the Wisconsin Diabetes Association announces that George F. Cahill, Jr., MD will deliver the annual guest lectureship at its meeting on February 28. Dr. Cahill, who is Professor of Medicine at the Harvard Medical School and Director of the Elliot P. Joslin Research Laboratories, will speak on metabolic perspectives in diabetes and related disorders.

Meeting will be held at the headquarters of Northwestern Mutual Life Insurance Company in Milwaukee. Social hour begins at 6:00 pm followed by a banquet and the lecture. Advanced registration is required. Further info: Wisconsin Diabetes Association, 225 East Michigan Ave., Milwaukee 53202.

Annual meeting of the Wisconsin Association for Perinatal Care will be held March 18–20 at the Pioneer Inn, Oshkosh. Theme of meeting will be *Perinatal Nutrition.* Dr. Roy Pitkin of the University of Iowa Medical School and Dr. Howard N. Jacobson of Harvard Medical School will be the main discussants on the educational program.

Info: Perinatal Secretary, Hartford Labs, St. Marys Hospital Medical Cer ter, 720 S. Brooks Street, Madison 5371

Tenth Annual Telemark Symposiu and Ski-Outing will be held Tuesda Wednesday, and Thursday, Feb. 13–1 1973, at Telemark Lodge near Cabl Sponsored by Indianhead Chapter, Wi consin Academy of Family Physician

Open to all interested persons. Facult from Mayo Clinic, Rochester, Minn again will present a scientific progra all three days, which is approved for si hours of prescribed credit.

Reception will be held for all pa ticipants on Tuesday evening. All sk equipment can be rented, and there ar private and group lessons. Rooms avail able in a new 200-room ski lodge, an 90 town houses on the hill. Also severa motels and lodges in the area.

Physicians attending are asked to mak their own room reservations (complet list of accommodations is available b writing: Manager, Mt. Telemark Sk Area, Cable, Wis.)

Registration fee of $10 for scientifi program, payable at the door. Furthe info: Wisconsin Academy of Famil Physicians, 2825 N. Mayfair Rd., Mil waukee, Wis. 53222.

Annual banquet of the Marquette-MCW Medical Alumni Association wil be held Saturday, March 24, at the Mil waukee Athletic Club. Social hour a 6:00 pm, and dinner at 8:00 pm. Din ner will include entertainment and danc ing, and presentation of alumnus of yea award.

Those alumni who graduated in 1923 1927, 1933, 1937, 1943, 1947, 1953 1957, 1963 and 1967 will have specia reunion get-togethers. Special recognition will be given to the class of 1948, celebrating its silver jubilee.

Reservations: Marquette–MCW Medical Alumni Association, 561 N. 15th St., Milwaukee 53233; (tel. 414/272–5450, ext. 250).

Midwest Regional Medical Symposium (Exercise and The Heart) and Physical Fitness Clinic will be held at the University of Wisconsin–La Crosse on March 29–31. It will feature one day devoted to the medical aspects of physical fitness and two days devoted to the role of the school in physical fitness, including sessions from the view of the handicapped program, the elementary program, and the secondary program. Clinic fee is $3.00 per person. Further info: Dr. Clifton De Voll, Associate Dean of HPER, University of Wisconsin–La Crosse, La Crosse 54601.

Third annual Great Lakes Health Congress, devoted to providing a comprehensive overview of practical solutions to major problems and issues in the health care field, will be held in McCormick Place-on-the-Lake, Chicago, Illinois April 16 through 18.

Theme of the Congress will be: "Challenging: New Dimensions of Health Care."

Congress is sponsored by three major organizations in the health services field: Tri-State Hospital Assembly, which is devoted to hospital care in Illinois, Indiana, Michigan and Wisconsin; the Mid-America Assembly, representing nursing homes in 10 midwestern states, and the Health Industries Association,

representing companies that manufacture and sell equipment used by hospitals and nursing homes.

Congress will include a series of general assemblies, educational conferences and seminars, all of which are directed towards keeping abreast of latest techniques and developing improved methods of operating hospitals and nursing homes.

Controversial Issues in Pediatric Cardiology, 1973, sponsored by The Division of Pediatric Cardiology at the University of Miami, to be held on Key Biscayne March 19–22. Sessions will be devoted to the principles of management of the infant undergoing intracardiac surgery and will include discussions of preoperative, operative, and postoperative management; surgical results in specific lesions in infants, e.g. pulmonary atresia with intact ventricular septum, transposition, tetralogy and total anomalous pulmonary veins; palliative surgery—status 1973; and recent advances in electrophysiology.

Program Director: Sidney Blumenthal, MD, Professor of Pediatric Cardiology, Associate Dean for Continuing Education. Place: Sonesta Beach Hotel, Key Biscayne, Fla. Fee: $125; $50 Fellows (with certification of Chief of Service). Inquiries: Division of Continuing Education, UofM School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

New Orleans Graduate Medical Assembly. Dr. William M. Lukash, White House Physician, and Head, Gastroenterology Clinic, U.S. Naval Hospital, will be one of the many distinguished speakers from throughout the country participating at the 36th annual meeting of The New Orleans Graduate Medical Assembly this year. Meeting dates are March 19–22, and headquarters will be again at the Fairmont Roosevelt Hotel. Dr. Lukash will speak on "Observations of Chinese Medicine," a report on his visit to China with President Nixon. Other well known physicians will report on medical advancements in their various specialties.

A continuous showing of medical motion pictures, luncheons for specialty groups, a clinicopathologic conference, technical exhibits, and planned entertainment for wives will add interest to the three and a half day meeting. This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by the American Academy of Family Physicians. Further info: The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La. 70112. (Also see advertisement elsewhere in this issue.)

Postgraduate Seminar on Emergency Medicine, sponsored by the Florida Chapter of the American College of Emergency Physicians and the Emergency Department Nurses Association, will be presented at the Playboy Plaza Hotel, Miami Beach, Florida from March 21–24.

This four-day program is designed to present current pertinent and practical information for those most intimately involved in delivering emergency medical care—the emergency physician, general and family physician, emergency nurse, hospital administrator, emergency medical technician, and community health planner. The latest knowledge and technology in emergency medicine will be surveyed by the guest faculty. Each registrant will receive a complimentary copy of the seminar's proceedings.

INFO: J. Clifford Findeiss, MD, Florida Chapter, American College of Emergency Physicians, Postgraduate Seminar on Emergency Medicine, 11130 S. W. 173rd Terrace, Miami, Florida 33157.

The 1973 American Industrial Health Conference will be held April 16–19 at Currigan Hall in Denver, Colo., with headquarters at the Denver–Hilton Hotel, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. This medical–nursing Conference which is comprised of the annual meetings of the two sponsoring organizations, will bring together approximately 2,500 persons including industrial physicians, industrial nurses, safety engineers, industrial hygienists, public health officials, academicians and management representatives.

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Postgraduate seminars and workshops in selected areas of industrial medical practice also will be presented. Registration is open to anyone having an interest in the health of the working population. Registration fee is $10.00. Advance program and registration forms are available from the American Industrial Health Conference, 150 North Wacker Drive, Chicago, Ill. 60606.

Fourth National Congress on MEDICAL ETHICS will be held April 26, 27, 28 at the Washington Hilton, Washington, D. C.

Among the subjects to be discussed will be: What is Medical Ethics; How Does the Student or the Resident or the Nurse See Medical Ethics; The Teaching of Medical Ethics; Medical Ethics and the New Biology; Voluntarism vs Compulsion; etc. As usual there will be a skit. This will be: "Grand Rounds on Medical Ethics."

Midwest Clinical Conference of the Chicago Medical Society and the Annual Meeting of the Illinois State Medical Society will be held March 25–28 at the Conrad Hilton Hotel in Chicago. Programmed with the cooperation of 30 specialty societies. Full-day trauma session. Fully-accredited instruction courses. Continuous medical film program. Scientific and technical exhibits. Special events and functions. Further info: Chicago Medical Society, 310 South Michigan Ave., Suite 1616, Chicago, Ill. 60604. (See ad elsewhere in this issue.)

National Conference on Urologic Cancer. Sponsored by the American Cancer Society in cooperation with American Urological Association, American College of Surgeons, American Society of Therapeutic Radiologists, and American Academy of Pediatrics, March 29–31, 1973 at the Shoreham Hotel in Washington, D. C.

The objective of this conference is to summarize the present knowledge in the field of urologic neoplasms for an interdisciplinary audience including the general practitioner, internist, surgeon, pediatrician, radiologist, and urologist.

Sessions are open to all members of the medical and related professions. Advance registration requested. No registration fee.

The Program is acceptable for 19 elective hours by the American Academy of Family Physicians.

Further info: Divisions of the American Cancer Society or Sidney L. Arje, MD, National Conference on Urologic Cancer, % American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

Cirrhosis and Portal Hypertension is subject of a postgraduate course sponsored by the American Gastroenterological Association as part of Digestive Disease Week.

The program will consist of four sessions. The first on Sunday afternoon, May 20, 1973, will provide a series of lectures by eminent workers who will discuss the normal and cirrhotic liver in terms of anatomy, pathology, circulation, fibrogenesis, and regeneration to provide basic background for the course.

On Monday, May 21, 1973, there will be two working sessions in which pathogenesis, diagnosis, and therapy of a variety of major complications of cirrhosis will be discussed by physicians, surgeons, and radiologists who are expert and active in their respective areas. These include hepatic coma, bleeding varices, portacaval shunts, hepatorenal syndrome, ascites, biliary cirrhosis, and Wilson's disease.

The final session will be a series of informal "Meet the Professor" Panels.

This course will be held in conjunction with the annual American Gastroenterological Association, AASLD, GRG, ASGE, and SSAT meetings as part of Digestive Disease Week at the Americana Hotel in New York from May 20 to 26, 1973.

Approval has been granted for 12 hours by the American Academy of Family Physicians.

All physicians are welcome. Registration fee is $80 for AGA and AASLD members; $100 for non-members; $25 for those in training status. Address all inquiries to: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, New Jersey 08086. □

Members of the State Medical Society of Wisconsin are invited to attend the many interesting scientific presentations and exhibits scheduled for the

1973 ANNUAL MEETING
of the
Wisconsin Dental Association

Meetings will be held Monday, May 7, through Wednesday, May 9, at the Milwaukee Auditorium. A physician's 1973 membership card will permit him to register. To register, use the Kilbourn Avenue entrance between the Auditorium and Arena.

CONTRIBUTIONS—CES FOUNDATION
November 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1972:

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Warnings: Use during pregnancy is to be avoided.

Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
(B) 98-146-103-D (6/72)

For complete details, including dosage, please see full prescribing information.

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Something of Value

If a man does away with his traditional way of living and throws away his good customs, he had better first make certain that he has something of value to replace them.

—BASUTO PROVERB

PRESIDENT'S PAGE

THE UNITED STATES SUPREME COURT on January 22, 1973, issued a mandate giving every woman in the nation the same right to an abortion during the first six months of a pregnancy as she has to any other minor surgery. It was variously described as a stunning denial of the rights of the unborn child; an unspeakable tragedy for this nation, and an exercise in judicial legislation. To me it was a monstrous giant step backward. The Court obviously values the convenience or whim of the mother more than the life of the unborn child which she carries. No mention whatever was made of the rights of the father.

The Court cited three familiar milestones in the intrauterine development of the unborn live infant—the first, second and third trimester of a pregnancy. Justice Harry Blackmun who wrote the majority opinion hinged the Court's decision upon the due process clause of the 14th Amendment relating to a citizen's right to life, liberty and the pursuit of happiness. To protect the infringement upon her "liberty," the pregnant woman may now elect an abortion. Justice Blackmun added that a fetus is not a person under the Constitution and thus has no legal right to life. There are millions of Americans across this land who do not concur with this conclusion.

The Court's legal decision will have a monumental direct effect upon some aspects of the practice of medicine. Just what will medical tissue committees do with normal fetal and placental tissue? Over the years, Wisconsin has been a leader in the field of maternal and child care. The maternal and infant mortality studies, premature institutes, neonatal and perinatal programs, all reflect the work and study directed by our Society in this sensitive area of medical care. The Court's abortion mandate now adds a lurid ironic dimension to this work of fetal salvage.

Surely the Court's decision on this most controversial medical–moral problem has been aptly voiced as a landmark decision. For many it was a moral turnabout. Another landmark decision of the Supreme Court in 1857—the Dred Scott decision—said that although he may have a beating heart and a functioning brain and be biologically human, the black man was not a legal person. It seems to me that we've now made a complete circle. What next?

Robert F. Purtell, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Peer Review Blues

In nearly thirty years of first hand contact with physicians and physicians' organizations, I've seen many issues that produced anger, disillusionment, or sometimes pleasure and solution. But in this time no issue has precipitated the amount of sheer anxiety that is now fomenting about the prospects for formal peer review. Utilization review is onerous but most persons accept it as necessary, learn the ground rules, and let it go at that. Membership itself is seldom challenged, whether in general or specialty societies, and then only for relatively serious breaches of professional or personal standards. But to review competency and develop effective means of making it stick, is another thing entirely. It is more personal.

The principle of peer review is difficult to challenge. We can all agree that our public and our third party payment groups are entitled to good care and reasonable value. In fact, I doubt if anyone could or would challenge the idea of meeting the ideals we learned in medical school, and which we all believe we have practiced. But who can assume the public and the body politic? Should it be an all nonmedical group, the ultimate consumer? Should the task be handed to specialized health delivery government servants? Or should we be satisfied with our elected representatives, within medical and specialty societies, and their appointed peer review committee members? Does political popularity grant the right or the ability to judge our fellow physicians? Is there any other way to do it? Regardless of the form peer review takes, be it corporation, committee or some sort of consensus, there is a very tricky problem of judgment, which will strain our intelligence as well as our goodwill to each other. Up to now it has been a matter of intellectual debate whether to follow the orthopedic route for treatment of ruptured disc or to use the neurosurgical procedures. What about the severe differences, both sides sincere, between heart surgeons and some cardiologists over the problems of coronary bypass. Or how do we decide whether a psychiatrist is negligent for talking to a depressed patient rather than hospitalizing him and giving electric shock within the first hour; or whether the shock-hospital route is dehu-

manizing? Of course these problems could be decided by a committee of three physicians appointed by the elected president of the medical society. But who should be appointed in the first instance: two orthopods and one neurosurgeon; or two neurosurgeons and one orthopod? Examples can multiply in the reader's mind in direct relation to how suspicious his thinking tends to be.

But even these strong practical problems pale compared to the observed personal anxiety centering about the prospect of having our private practice peered at, even by previously friendly peers, particularly if payment for professional service or worse the privilege of practicing at all, rides on the precise way the process comes out.

Most physicians have valued their integrity, have practiced well, kept up at least on the varieties of new discoveries and methods of treatment. However, the need to let this integrity be examined by those others with whom we spend our professional lives produces a chill in more than one physician. Strangely this chill, or fear, or anxiety has not seemed to me to be related to competency at all. Of course, here I presume to know what competency is, and another may challenge me, indeed likely will. Put another way, I've seen severe anxiety, over the prospect of opening up office records, in physicians whose training experience and certifications would almost certainly guarantee successfully passing most any review. No quick answer can be given why this should be so. Government agents, third party groups, lay politicians and others assure us that, as President Roosevelt said so many years ago, all we have to fear is fear itself. Maybe so, but is that not a serious factor all in itself? I think so and choose to address this editorial toward the hope that by taking into serious account the rather sensitive need for privacy and integrity we may devise more effective peer review systems, hopefully not of the Spartan (or more properly "sadistic") variety where we roughly say "shape up fellow" or "if you are OK, why should you have any anxiety?". It just is not that simple. We do have anxiety, partly about our continuing need to learn, partly about our sensitivity to whether *all* our judgments are correct, partly about whether personal feelings of many sorts may color our peer's judgment of our work. It really is easy to forget the biblical question of who should cast the first stone.—RH □

OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of Article XIII of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the May 1972 annual session of the House of Delegates, are being published in the January and February, 1973, issues of the WISCONSIN MEDICAL JOURNAL, prior to House of Delegates' action at the March 1973 annual session.

* * *

Society's Purpose Clause: Amend Article II entitled "Purpose" as follows:

In the first and second lines of Article II delete the words "federate and".

In the tenth line delete "to promote friendly intercourse" and substitute "to promote open communication and understanding".

Therefore, Article II would then read: The Purposes of this Society shall be to bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

Election of Councilors: Amend Article IX entitled "Officers" as follows:

Delete the second paragraph which now reads: "Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated." Re-create the second paragraph of Article IX to read: "Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the confirmation of the House of Delegates."

"Mini Transfusions" in Neonatal Patients—Error in Heparin Dosage Noted

The recent article by McCormick, et al [*Wisconsin Medical Journal* 71:248 (1972)] of Green Bay, Wisconsin, regarding "Mini Transfusions" for Neonatal Patients outlined some very useful suggestions on certain aspects of the technique, such as the care in maintaining asepsis, the use of the Fenwal infusion set with filter, and the method of preparing packed cells.

However, there are some aspects of this article that deserve comment. The concentration of heparin in their system is 250 units heparin per 30 cc blood, which is roughly twice that used in routine blood bank heparinizations (2075 units/500 cc, or 124 units heparin per 30 cc). The article should have contained a warning and suggestion that physicians using such heparinized "Mini Transfusions" follow those transfusions with an appropriate amount of protamine sulfate. A 2 Kg newborn receiving 10 cc per kilogram of this blood would also receive over 80 units of heparin per kilogram, which is nearly the amount recommended (100 units/kilo) for heparinization of neonates with disseminated intravascular coagulation [*Clinical Pediatrics* 10:11 (1972)]. This amount of heparin given in the "Mini Transfusion" to a sick neonate could well potentiate a coagulation problem, or precipitate central nervous system bleeding. Our fresh blood neonatal transfusions contain 25–35 units of heparin per 10 cc blood, ⅓ that described by the authors. Even then, we have found that the neonate's partial thromboplastin time (PTT) is almost always tripled by these fresh blood transfusions, and therefore we routinely follow such transfusions with protamine sulfate, 1.0 mg/100 units of heparin, intravenously, which corrects the PTT within minutes.

Fresh blood "mini transfusions" are important to neonates for other reasons in addition to replacing blood loss. Fresh whole adult blood contains coagulation factors, red cells with adequate 2,3, DPG, and opsonins which facilitate WBC phagocytosis, to name a few. With the technique described by McCormick et al, the blood, after drawn, must await typing and crossmatching. It seems possible that storage for that length of time could lead to loss of some of these beneficial factors. Drawing blood for type and crossmatch, then later drawing the blood for the transfusion directly is an alternative method.

RICHARD D. ZACHMAN, PhD, MD
Director
Neonatal Intensive Care Unit
St. Mary's Hospital Medical Center
Madison, Wisconsin

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Author's Comments on Doctor Zachman's Evaluation

Doctor Zachman is entirely correct in his evaluation of the heparin dosage listed in the article. The method is from the American Association of Blood Bank's *Technical Methods and Procedures,* 5th edition, 1970. Using this technique, which is used at our hospital, the content of the 30 cc mini-transfusion vial is 135 units and not 250 units as listed in the article. This error should be noted. In the event the mini-transfusion is prepared using the units given in the article, the dosage of heparin is too high. Under these circumstances, protamine is indicated. Most of the replacement units are packed red cells and under these circumstances, relatively little heparin is infused.

We do not recommend the use of mini-transfusions for the treatment of coagulation disorders as it is usually easier to use component therapy. The heparinized blood is intended primarily to replace erythrocytes, and therefore, the time factor referred to by Doctor Zachman is not critical.

Table 15 of the AABB *Technical Methods and Procedures* is enclosed for the calculation of heparin dosage. The article on "Mini-transfusions" correctly lists the volume at 1.8 cc of heparin solution, but erroneously listed this amount as 250 units of heparin when in fact it is 135 units.

R. A. MCCORMICK, MD
St. Vincent Hospital
Green Bay, Wisconsin □

TABLE 15
ANTICOAGULANT FORMULAS

	ACD Solution Formula A 100 ml contains	CPD Solution 100 ml contains
Sodium citrate, hydrous, USP	2.2 gm	2.63 gm
Citric acid, hydrous, USP	0.8 gm	0.327 gm
Monobasic Sodium Phosphate, Monohydrate, USP	—	0.222 gm
Dextrose, hydrous, USP	2.45 gm	2.55 gm
Water for injection, USP	to 100 ml	to 100 ml
Volume used per 100 ml of blood to be drawn	15 ml	14 ml
Volume used for collection of 450 ml of blood	67.5 ml	63 ml

Heparin Solution	100 ml contains
Heparin Sodium, USP	7,500 units
Sodium Chloride Injection, USP, buffered with Sodium Phosphates	to volume
Volume used per 100 ml of blood to be drawn	6 ml
Volume used for collection of 450 ml of blood	27 ml

STATE MEDICAL SOCIETY OF WISCONSIN
SERVICES TO MEMBERS

- Health Educational Activities
- Film Service
- Health Careers Information
- Speakers Service
- Voluntary Health Agency Contacts
- Student Loans
- Grievance Services
- Museum of Medical Progress and Stovall Hall of Health
- Executive Office Services
- *Wisconsin Medical Journal*
- Life Insurance
- Disability Income Protection
- Wisconsin Work Week of Health
- Business Overhead Insurance
- WPS—Blue Shield Protection
- Open Panel Program under Workmen's Compensation
- Continuing Medical Education Programs
- Physician Placement Services
- Medicolegal Consultation
- Professional Liability Consultation
- Public Relations
- Legislative Representation
- Governmental Agency Contacts
- Medical Economic Advice

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/Clinical Practice."

HOW THE
State Medical Society of Wisconsin
SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use and to serve. To benefit fully from his or her membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the second in a series of articles explaining State Medical Society organization and activities.

Multiple Education Projects
for the Physician and the Public

EDUCATION IS ONE of the main concerns of the State Medical Society. This includes not only physician education but also programs for other health professionals and the public.

Physician Education

Medical education in Wisconsin is a traditional concern of the State Medical Society. Efforts by the Society in the last century to establish University of Wisconsin programs leading to a medical degree led to the creation of a medical school on that campus.

The deans at both the University of Wisconsin Medical School and the Medical College of Wisconsin are ex officio members of the Society's Commission on Hospital Relations and Medical Education. Among the concerns of this commission are medical school curricula, use of clinical material, preceptor programs, internships, and residencies. The commission is an avenue through which physicians in practice throughout the state can take part in shaping these programs.

As the result of increasing concern throughout the state about the need for more family physicians, the Commission on Hospital Relations and Medical Education has met with medical school faculty and hospital representatives on the establishment of family medicine training programs. The commission's recommendations have also resulted in a formal request by the State Society for state legislative support of these programs.

Continuing Education

The continuing postgraduate education of state physicians is also an important concern of the State Medical Society. Through its Speakers Service, a diversified group of medical experts is available to speak at meetings of county medical societies and councilor districts. This service brings physicians across the state up-to-the-minute reports on progress in research and treatment in all areas of medicine.

A regular educational resource for all State Medical Society members is the *Wisconsin Medical Journal*, the Society's official publication. Each month it contains scientific articles, written generally, by state physicians, that are of interest to those in both general and specialty practice. In addition to keeping members advised of new developments in medicine, the *Journal* serves as a stimulus to investigation of clinical problems and the publication of findings. An Editorial Board, appointed by the Society's Council, reviews manuscripts submitted for publication.

Each year the Society presents a broad scientific educational program that draws wide physician participation as part of the Society's Annual Meeting. This includes general and specialty lectures, demonstrations, "wet clinics," motion pictures, and scientific and technical exhibits.

During the winter months in-depth teaching programs are held. These devote an entire day to one topic, such as acute stroke, diabetes or obesity. Lectures, discussions and demonstrations by experts give the practitioner intense exposure to the latest in research and treatment. The Charitable, Educational and Scientific Foundation of the Society presents these teaching programs in cooperation

■ *All ages come to the Museum of Medical Progress in Prairie du Chien to learn the story of medicine and the human body.*

■ *Scientific exhibits from around the state are a highlight of the Society's Annual Meeting.*

with the Wisconsin Academy of Family Physicians, the University of Wisconsin, and the Postgraduate Teaching Program of Merck, Sharp & Dohme.

In another project, the Foundation cooperates with the Wisconsin Academy of Family Physicians to offer the Freshman Medical Student Summer Externship Program. This provides a ten-week externship with family physicians for students who have completed their freshman year of medical school.

It is hoped this experience in the primary sector of medicine at an early stage in the student's medical career will also encourage students attending Wisconsin medical schools to establish their practices in this state when their education is completed.

Participating students receive fellowship grants from the Foundation, drawn from contributions by physicians, hospitals, Wisconsin Physicians Service–Blue Shield, Surgical Care–Blue Shield, American Family Insurance, and the Wisconsin Rural Rehabilitation Corporation.

Much of the work carried on through the State Medical Society's commissions and committees can also be considered of an educational nature. For example, the Society's Committee on Cancer has recently played a role in the development of a Tumor Registry in Dane County. Through the Tumor Registry, statistics on cancer incidence and treatment can be evaluated and become a part of active teaching programs.

Public Education

Well trained physicians are only a part of the story of good health care.

The State Medical Society also plays an active role in public education. Among its most ambitious projects is an annual week-long public symposium, the Wisconsin Work Week of Health. The Work Week provides a forum for the exchange of information on the status of health in Wisconsin through lectures, panel discussions, and group involvement.

In the past, the Work Week has dealt with topics such as medicine and religion, traffic safety, alcoholism, and care of the aged. It has also included special programs for Wisconsin youth on drugs, driving, grooming, smoking, and sports. In 1969 through the use of television, some 2,000,000 people were reached by the Work Week program the "Drug Turn On," which was cosponsored by dozens of state health organizations.

On a regular basis some three dozen radio stations across the state carry the "March of Medicine." This is a weekly 15-minute program which provides the public with sound health advice on common problems. Public service articles for newspapers and special publications are also produced through the State Medical Society.

Another well-known Society activity in health education is its Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

Using lights, sound, and action in its exhibits, the Museum presents the story of the human body in sickness and in health as well as an historic look at Wisconsin's frontier days. Exhibit topics have included anatomy, medical history, ecology, medical art, pharmacology, veterinary science—the whole gamut of medicine and its concerns.

The Museum's location is the site of a frontier fort where Dr. William Beaumont did experiments which laid the basis of our knowledge of digestion. His work with "the man with a hole in his stomach" was done there in the 1830s.

The Society's Madison headquarters has many other public health education resources available on request. These include films, exhibits, and literature on health subjects ranging from acupuncture to warts.

Speakers, films, exhibits, and pamphlets are provided for meetings sponsored by physicians, woman's auxiliary groups or others on topics related to personal health or economic and social aspects of medicine. In addition, up-to-date informative materials on all health career opportunities are provided upon request. The Society carries out joint programs with the Wisconsin Health Council to interest and attract men and women to careers in the health field.

The commission of the Society that concerns itself most directly with public health education is the Commission on Health Information. By working with county medical societies, the American Medical Association, and other groups involved in health education, it coordinates public information programs involving the State Medical Society. □

1973 ANNUAL MEETING

THEME: *"Evaluation and Therapy of Common Endocrine Disorders"*

Scientific Program

IN CONDENSED FORM

State Medical Society of Wisconsin

MAR. 26-27

MILWAUKEE

HOTEL PFISTER

STATE MEDICAL SOCIETY OF WISCONSIN

Business Schedule

NOTE: *All business meetings* including House of Delegates, Reference Committees, Council, Council Committees, and related functions will be held at the Hotel Pfister in Milwaukee

FRIDAY, MARCH 23

Executive Committee of the Council
Dinner and Meeting

SATURDAY, MARCH 24

Council Luncheon and Meeting
Awards Dinner—50 Year Club and others
Councilors and Officers

SUNDAY, MARCH 25

Section Delegates Caucus Meeting
First Session of the House of Delegates
Reports of officers, commissions, and committees, and new business
House of Delegates Buffet Supper
Reference Committees

MONDAY, MARCH 26

Nominating Committee
Second Session of the House of Delegates
Reports of Reference Committees
President's Reception
Public Affairs Dinner

TUESDAY, MARCH 27

Third Session of the House of Delegates
Election of officers
Council Meeting
Charitable, Educational and Scientific Foundation Board of Trustees Meeting
Council and CESF Board of Trustees Luncheon

See the TIMETABLE for details on time and room locations

TIMETABLE

Annual Meeting: State Medical Society of Wisconsin, Hotel Pfister, March 23–27, 1973

Annual Meeting: Woman's Auxiliary to SMS, Holiday Inn Central (HI), March 25–27, 1973

Milwaukee, Wisconsin

FRIDAY, MARCH 23

p.m.

6:00 Council Executive Committee Dinner (Empire Rm.)

7:30 Council Executive Committee Meeting (Empire Rm.)

SATURDAY, MARCH 24

a.m.

9:00 Southeastern Wisconsin Cancer Conference (Imperial Ballroom)

noon

12:00 Southeastern Wisconsin Cancer Conference Luncheon (Hall of Presidents)

12:00 Council Luncheon (Cafe Rouge)

p.m.

2:00 Council Meeting (Henry VIII Rm.)

5:30 Awards Dinner (Imperial Ballroom) (50 Year Club; Councilors and Officers)

6:00 Marquette–Medical College of Wisconsin Medical Alumni Association (Milwaukee Athletic Club)

SUNDAY, MARCH 25

a.m.

10:30 Section Delegates Caucus Meeting (Richard & Charles Rms.)

11:00 Wisconsin Academy of Family Physicians Meeting and Luncheon (Henry VIII & Louis XIV Rms.)

p.m.

1:00 House of Delegates Registration (Foyer)

2:00 House of Delegates, First Session (Imperial Ballroom)

2:00 Auxiliary Hospitality Room (Coach N' Four) HI

2:00 Auxiliary Registration (Coach N' Four) HI

4:00 to 8:00 Medical Antique Show (Villa Terrace)

5:30 House of Delegates, Buffet Supper (Henry VIII & Louis XIV Rms.)

7:00 REFERENCE COMMITTEES:
- Resolutions & Amendments (Imperial Ballroom)
- Reports of Standing Committees (McKinley Rm.)
- Reports of Officers (Taft Rm.)
- Finance (Richard II Rm.)

7:00 to 9:00 Open Hearing of Planning Committee (Roosevelt & Kennedy Rms.)

MONDAY, MARCH 26

a.m.

7:30 Medicine and Religion Breakfast

8:30 Auxiliary Registration (Second Fl.) HI

8:30 Auxiliary Continental Breakfast (Coach N' Four) HI

9:00 Plenary Session: Sections on Family Physicians, Internal Medicine, Pediatrics (Grand Ballroom East)

9:30 Auxiliary Board of Directors Meeting (Coach Light Rm.) HI

10:30 Auxiliary Business Session (Coach Light Rm.) HI

continued

TIMETABLE—continued

p.m.

12:15 Socio-economic luncheon open to all members of Society (Imperial Ballroom)

1:00 Auxiliary Anniversary Luncheon (Garden Terrace Rm.) HI

2:00 Plenary Session: Sections on Dermatology & Public Health, Wisconsin Allergy Society (Grand Ballroom, East)

2:00 Nominating Committee (Executive Conference Rm., Mezzanine Fl.)

2:00 to 4:00 Open Hearing of Planning Committee (Empire Rm.)

3:00 House of Delegates Registration (Foyer)

3:00 Auxiliary Business Session (Coach Light Rm.) HI

4:00 House of Delegates, Second Session (Imperial Ballroom)
NOTE: Must adjourn no later than 6:00 p.m.

4:30 Auxiliary Market Place (Coach N' Four) HI

5:00 Wisconsin Allergy Society Business Meeting (Roosevelt & Kennedy Rms.)

5:00 Section on Internal Medicine Business Meeting (Taft & McKinley)

5:00 Section on Public Health Business Meeting (Charles I)

6:30 President's Reception (all rooms of King's Row)

7:30 Public Affairs Dinner (Imperial Ballroom)

TUESDAY, MARCH 27

a.m.

7:00 House of Delegates Registration (Foyer)

8:00 House of Delegates, Third Session (Imperial Ballroom)

8:30 Auxiliary Registration (Second Fl.) HI

8:30 Auxiliary Breakfast (Coach N' Four) HI

8:30 Resident–Intern Papers Program (Grand Ballroom East)

8:30 Wet Clinic (Surgery) Milwaukee County General Hospital

10:00 Auxiliary Business Session (Coach Light Rm.) HI

10:00 Plenary Session: Sections on Pathology and Radiology (Grand Ballroom East)

10:00 Wet Clinic (Otolaryngology) VA Hospital, Wood (Rm. B-609)

10:30 Council Meeting (Crown Rm. 23rd Fl.)

11:30 Board of Trustees, Charitable, Educational and Scientific Foundation Meeting (Crown Rm.)

noon

12:00 Wet Clinic (Surgery) Luncheon (Milwaukee County General Hospital)

p.m.

12:15 Luncheons—followed by afternoon program
- Pathology (Roosevelt Rm.)
- Plastic Surgery (Milwaukee Athletic Club)
- Radiology (Kennedy Rm.)
- Anesthesia (½ Imperial Ballroom)
- Orthopedics (½ Imperial Ballroom)
- Ophthalmology (Louis XIV & Henry VIII Rms.)
- Otolaryngology (Richard II & Charles I Rms.)
- Obstetrics & Gynecology (McKinley & Taft Rms.)
- Wisconsin Trauma Committee (Rm. 601)

12:30 Council and Board of Directors, CESF, Past Presidents, Luncheon (Crown Rm.)

2:00 Surgical Section Program (Grand Ballroom East)

6:00 Wisconsin Orthopedic Society: Milwaukee Athletic Club

6:30 Radiology Dinner: Marriott Motor Inn (Brookfield)

6:30 Wisconsin Surgical Society: Milwaukee Athletic Club

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

WALTER F. BALLINGER, MD

Bixby Professor and Chairman, Department of Surgery, Washington University, St. Louis, Mo.

TUESDAY, MARCH 27: 2:30 pm—*Surgical Management of Endocrine and Exocrine Lesions of the Pancreas*

S. J. BEHRMAN, MD

Professor of Obstetrics & Gynecology and Director Center for Research in Reproductive Biology, University of Michigan Medical Center, Ann Arbor, Mich.

TUESDAY, MARCH 27: 2:30 pm—*Medical Management of Anovulation;* 3:30 pm—*Investigation of Oligo-amenorrhea*

BEVERLEY A. BRITT, MD

Department of Pharmacology, University of Toronto, Toronto, Canada

TUESDAY, MARCH 27: 2:00 pm—*The Present Status of Malignant Hyperthermia*

RICHARD M. CAPLAN, MD

Professor of Dermatology and Assistant Dean for Continuing Medical Education, University of Iowa College of Medicine, Iowa City, Ia.

MONDAY, MARCH 26: 2:20 pm—*Cutaneous Manifestations of Diabetes*

PAUL H. CURTISS, JR., MD

Professor and Director, Division of Orthopaedics, Department of Surgery, Ohio State University, Columbus, Ohio

TUESDAY, MARCH 27: 12:15 pm—*The Dilemma of Osteosarcoma;* 6:00 pm—*Fractures of the Shaft of the Femur in Children*

LYTT I. GARDNER, MD

Professor of Pediatrics, State University of New York, Upstate Medical Center, Syracuse, N. Y.

MONDAY, MARCH 26: 11:30 am—*Congenital Hypothyroidism*

FREDERICK C. GOETZ, MD

Professor of Medicine, University of Minnesota Medical School, Section of Endocrinology & Diabetes Clinic, Minneapolis, Minn.

MONDAY, MARCH 26: 10:00 am—*Diabetes—End Stage as Treated by Transplantation*

CHARLES E. ILIFF, MD

Associate Professor of Ophthalmology, Johns Hopkins University and School of Medicine, Baltimore, Md.

TUESDAY, MARCH 27: 2:00 pm—*Surgical Management of Mucoceles that Present in the Orbit; Dacryocystorhinostomy*

MARILYN M. KRITCHMAN, MD

Associate Professor of Clinical Anesthesiology, State University at Stony-Brook, Great Neck, N. Y.

TUESDAY, MARCH 27: 3:30 pm—*Obesity and Anesthesia*

PAUL E. LACY, MD

Chairman, Department of Pathology, Washington University School of Medicine, St. Louis, Mo.

MONDAY, MARCH 26: 9:00 am—*Beta Cell Secretion*

TUESDAY, MARCH 27: 10:00 am—*Islet Cell Tumors of the Pancreas with Associated Syndromes*

ROY PATTERSON, MD

Northwestern University Medical School, Chicago, Ill.

MONDAY, MARCH 26: 3:30 pm—*Allergy to Insulin*

FRANCIS F. RUZICKA, JR., MD

Director, Department of Radiology, St. Vincents Hospital, and Medical Center of New York, New York City

TUESDAY, MARCH 27: 11:00 am—*Angiography of the Parathyroids;* 2:00 pm—*Radiology of Portal Hypertension*

THEODORE C. SMITH, MD

Professor of Anesthesiology, University of Pennsylvania, Philadelphia, Pa.

TUESDAY, MARCH 27: 4:15 pm—*Endocrine Disorders and Their Effect on Respiration*

SHELDON C. SOMMERS, MD

Clinical Professor of Pathology, Director of Laboratories, Lenox Hill Hospital, Columbia and University of Southern California, New York City

TUESDAY, MARCH 27: 2:00 pm—*Adrenal Cortex;* 11:25 am—*Tumors of the Adrenal Medulla*

M. STUART STRONG, MD

Professor of Otolaryngology, Boston University Medical School, Boston, Mass.

TUESDAY, MARCH 27: 1:30 pm—*Laser Therapy in Otolaryngology*; 3:45 pm—*Endocrine Problems in Otolaryngology*

EDWARD E. WALLACH, MD

Director, Obstetrics & Gynecology, Pennsylvania Hospital; Professor of Obstetrics & Gynecology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

TUESDAY, March 27: 2:00 pm—*Management of Dysfunctional Uterine Bleeding*

PRESIDENT'S RECEPTION

Monday, March 26—6:30 pm

HOTEL PFISTER—King's Row

Everyone attending the Annual Meeting is invited to join President Robert F. Purtell in welcoming the new President, Dr. Gerald J. Derus, and his wife, at an informal reception.

FRUIT PUNCH HORS D'OEUVRES

Steve Swedish Music

PUBLIC AFFAIRS Dinner

Monday, March 26—7:30 pm

HOTEL PFISTER—Imperial Ballroom

Sponsored jointly by the State Medical Society of Wisconsin and Woman's Auxiliary to the State Medical Society.

Followed by program at 8:30 pm

featuring

ROSE AND HOYT GARDNER

MONDAY, MARCH 26

9:00 am to 12:00 noon—Scientific Program

PLENARY SESSION: Morning

Presented by Sections on Family Physicians, Internal Medicine and Pediatrics

BETA CELL SECRETION
Paul E. Lacy, MD, St. Louis, Mo.: Chairman, Department of Pathology, Washington University School of Medicine

DIABETES MELLITUS: CURRENT CONTROVERSIES
Ronald Kalkhoff, MD, Milwaukee; Associate Professor of Medicine, Medical College of Wisconsin

DIABETES: END-STAGE AS TREATED BY TRANSPLANTATION (Elvehjem Memorial Lecture)
Frederick C. Goetz, MD, Minneapolis, Minn.; Professor of Medicine, University of Minnesota Medical School, Section of Endocrinology and Diabetes Clinic

DIABETIC CARE IN A RURAL SETTING
Phillips T. Bland, MD, Westby

JUVENILE DIABETES MELLITUS: INSULIN, PROINSULIN AND C-PEPTIDES
Gerald J. Bargman, MD, Madison; Assistant Professor of Pediatrics, Division of Pediatric Endocrinology, University of Wisconsin Medical School

CONGENITAL HYPOTHYROIDISM
Lytt I. Gardner, MD, Syracuse, N. Y.; Professor of Pediatrics, State University of New York, Upstate Medical Center

12:15 pm—Socio-economic Luncheon

One large luncheon program open to all members of State Medical Society on a socio-economic topic presented by a prominent public figure (to be announced).

2:00 pm—Scientific Program

PLENARY SESSION: Afternoon

Presented by Wisconsin Allergy Society and Sections on Dermatology and Public Health

PUBLIC HEALTH ASPECTS OF CLINICAL ENDOCRINE PROBLEMS
Edgar S. Gordon, MD, Madison, Professor of Medicine, University of Wisconsin Medical School

CUTANEOUS MANIFESTATIONS OF DIABETES
Richard M. Caplan, MD, Iowa City, Ia., Professor of Dermatology and Assistant Dean for Continuing Medical Education, University of Iowa College of Medicine

DIABETIC RETINOPATHY
Matthew D. Davis, MD, Madison; Professor of Ophthalmology, University of Wisconsin Medical School

ALLERGY TO INSULIN
Roy Patterson, MD, Chicago, Ill.; Northwestern University Medical School

PANEL: ENDOCRINE DISORDERS

TUESDAY, MARCH 27

8:30 to 9:30 am—Special Program

RESIDENT–INTERN PAPERS

(See box elsewhere in this issue)

8:30 to 12:00 noon—Surgery Program

WET CLINIC: Case presentations and discussions

BUSINESS MEETING: Wisconsin Surgical Society

10:00 to 11:45 am—Otolaryngology Program

WET CLINIC: Case presentations and discussions

10:00 am to 12:00 noon—Scientific Program

PLENARY SESSION: Morning

Presented by Sections on Pathology and Radiology

ISLET CELL TUMORS OF THE PANCREAS WITH ASSOCIATED SYNDROMES
Paul E. Lacy, MD, St. Louis, Mo.; Chairman, Department of Pathology, Washington University School of Medicine

ANGIOGRAPHY OF THE PANCREAS
Frank E. Maddison, MD, Milwaukee

ANGIOGRAPHY OF THE PARATHYROIDS
Francis F. Ruzicka, MD, New York City; Director, Department of Radiology, St. Vincent's Hospital and Medical Center of New York

TUMORS OF THE ADRENAL MEDULLA
Sheldon C. Sommers, MD, New York City; Director of Laboratories, Lenox Hill Hospital; Clinical Professor of Pathology, Columbia and University of Southern California

DIAGNOSIS OF ADRENAL LESIONS USING CATHETERS
W. A. Smullen, MD, Marshfield

12:15 to 1:30 pm—Scientific Section Luncheons

Followed by afternoon programs

1. ANESTHESIA: *Theodore C. Smith, MD,* Philadelphia
2. OBSTETRICS/GYNECOLOGY: Film—"Colposcopy"
3. OPHTHALMOLOGY: No speaker. Business meeting.
4. ORTHOPEDICS: "The Dilemma of Osteosarcoma," *Paul H. Curtiss, Jr., MD,* Columbus, Ohio
5. OTOLARYNGOLOGY: No speaker.
6. PATHOLOGY: "Adrenal Cortex," *Sheldon C. Sommers, MD,* New York City
7. RADIOLOGY: "Radiology of Portal Hypertension," *Francis F. Ruzicka, MD,* New York City
8. WISCONSIN COMMITTEE ON TRAUMA: American College of Surgeons

2:00 pm—Scientific Program

1. ANESTHESIA

THE PRESENT STATUS OF MALIGNANT HYPERTHERMIA
Beverley A. Britt, MD, FRCP(C), Toronto, Canada; Assistant Professor of Anesthesiology, University of Toronto

OBESITY AND ANESTHESIA
Marilyn M. Kritchman, MD, Great Neck, N. Y.; Associate Professor of Clinical Anesthesiology, State University at Stony-Brook; Attending Anesthesiologist, Nassau County Medical Center

ENDOCRINE DISORDERS AND THEIR EFFECT ON RESPIRATION
Theodore C. Smith, MD, Philadelphia, Pa.

BUSINESS MEETING

2. OBSTETRICS/GYNECOLOGY

MANAGEMENT OF DYSFUNCTIONAL UTERINE BLEEDING
Edward E. Wallach, MD, Philadelphia, Pa.; Director, Obstetrics and Gynecology, Pennsylvania Hospital; Professor of Obstetrics and Gynecology, University of Pennsylvania School of Medicine

MEDICAL MANAGEMENT OF ANOVULATION
S. J. Behrman, MD, Ann Arbor, Mich.; Professor of Obstetrics and Gynecology; Director, Center for Research in Reproductive Biology, University of Michigan Medical Center

POST PILL AMENORRHEA AND INFERTILITY
Roland A. Pattillo, MD, Milwaukee; Associate Professor, Department of Gynecology and Obstetrics, Medical College of Wisconsin

CHROMOSOME AND MENSTRUAL ABNORMALITIES AND INFERTILITY
Gloria E. Sarto, MD, Madison; Associate Professor, Department of Obstetrics and Gynecology, University of Wisconsin Medical School

AMENORRHEA—EVALUATION AND BASIS
Edward E. Wallach, MD, Philadelphia, Pa.

INVESTIGATION OF OLIGO–AMENORRHEA
S. J. Behrman, MD, Ann Arbor, Mich.

3. OPHTHALMOLOGY

SURGICAL MANAGEMENT OF MUCOCELES THAT PRESENT IN THE ORBIT AND DACRYOCYSTORHINOSTOMY
Charles E. Iliff, MD, Baltimore, Md.; Associate Professor, Johns Hopkins University and School of Medicine

CLINICO–PATHOLOGIC CORRELATION
Guillermo de Venecia, MD, Madison; Associate Professor of Ophthalmology, University of Wisconsin Medical School

4. ORTHOPEDICS

SNOWBLOWER INJURIES TO THE HAND
George L. Lucas, MD, Madison; Assistant Clinical Professor of Surgery (Orthopedics), University of Wisconsin Medical School

A TECHNIQUE FOR SALVAGE OF THE INFECTED DIABETIC GANGRENOUS FOOT
Alfred E. Kritter, MD, Waukesha; Orthopedic Surgeon

AVASCULAR NECROSIS OF THE HIP IN YOUNG CHILDREN
Donald R. Gore, MD, Sheboygan; Assistant Clinical Professor, Department of Orthopedic Surgery, Medical College of Wisconsin

CRYOSURGICAL EFFECTS ON THE EPIPHYSEAL PLATE
C. Hugh Hickey, MD, Milwaukee; Assistant Clinical Professor, Orthopedic Surgery, Medical College of Wisconsin
Paul Jacobs, MD, Milwaukee

5. OTOLARYNGOLOGY (starts at 1:30 pm)

LASER THERAPY IN OTOLARYNGOLOGY
M. Stuart Strong, MD, Boston, Mass.; Professor of Otolaryngology, Boston University Medical School

COMPLICATIONS FOLLOWING LARYNGEAL CANCER SURGERY
John C. Dailey, MD, Madison; Senior Resident in Otolaryngology, University of Wisconsin Medical School

STEROID THERAPY IN ALLERGY, INFECTION AND SURGERY
Paul S. Rosenfeld, MD, Milwaukee; Assistant Professor of Medicine, Medical College of Wisconsin; Chief of Endocrine–Metabolic Section, VA Center, Wood

OTOLARYNGOLOGIC MANIFESTATIONS OF THE ENDOCRINOPATHIES
Thomas M. Kidder, MD, Milwaukee; Senior Resident in Otolargyngology, VA Center, Wood

PANEL: ENDOCRINE PROBLEMS IN OTOLARYNGOLOGY
M. Stuart Strong, MD, Boston, Mass.
Paul S. Rosenfeld, MD, Milwaukee

BUSINESS MEETING

continued on next page

SPECIAL PROGRAM

Presentation of

RESIDENT–INTERN PAPERS

TUESDAY, MARCH 27 (8:30–9:30 am)

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the other as the HARRY BECKMAN AWARD

Chairman: *Edwin C. Albright, MD,* Madison

Presentations will be limited to ten minutes each

JUDGES: Edwin C. Albright, MD, Madison, Chairman; Anthony V. Pisciotta, MD, Milwaukee; and Richard I. H. Wang, PhD, MD, Milwaukee

TUESDAY *continued*

2:00 pm—Scientific Program

6. PATHOLOGY

ADRENAL CORTEX

Sheldon C. Sommers, MD, New York City; Director of Laboratories, Lenox Hill Hospital; Clinical Professor, Columbia and University of Southern California

7. RADIOLOGY

RECENT ADVANCES IN ANGIOGRAPHY OF THE PARATHYROID GLANDS

Francis F. Ruzicka, Jr., MD, New York City; Director, Department of Radiology, St. Vincents Hospital and Medical Center of New York

8. SURGERY (starts at 1:45 pm)

BILE REFLUX GASTRITIS

Eugene E. Eckstam, MD, Monroe; The Monroe Clinic
Harold H. Scudamore, MD, Monroe; Department of Gastroenterology, The Monroe Clinic

SURGICAL EXPERIENCE IN THE TREATMENT OF THYROID DISORDERS

Albert G. Martin, MD, Milwaukee

THYMECTOMY FOR MYASTHENIA GRAVIS

Raymond R. Watson, MD, Milwaukee

SURGICAL MANAGEMENT OF ENDOCRINE AND EXOCRINE LESIONS OF THE PANCREAS (William Beaumont Memorial Lecture)

Walter F. Ballinger, MD, St. Louis, Mo.; Bixby Professor of Surgery and Head of the Department, Washington University School of Medicine

CLINICAL RESULTS AND SURVIVAL WITH INTRA-HEPATIC ARTERIAL INFUSION IN 300 PATIENTS

Fred J. Ansfield, MD, Madison, Professor, Division of Clinical Oncology, University of Wisconsin Medical School

SURVEY OF THE GENERAL SURGICAL SERVICES IN THE STATE OF WISCONSIN

Marvin Wagner, MD, Milwaukee; Associate Clinical Professor, Department of Surgery; Associate Clinical Professor, Department of Anatomy, Medical College of Wisconsin

ABDOMINAL ECTOPIC HYPERPARATHYROIDISM

Thomas J. Foley, MD, Milwaukee; Assistant Clinical Professor of Surgery, Medical College of Wisconsin

MANAGEMENT OF PREMATURE INFANTS REQUIRING PATENT DUCTUS LIGATION

George P. Steinmetz, MD, Madison

THE PROBLEMS OF SURGEONS: THE PROBLEM SURGEON (Presidential Address)

Wilson Weisel, MD, Milwaukee

BUSINESS MEETING: Section on Surgery

SOCIO-ECONOMIC LUNCHEON

Monday, March 26—12:15 pm

HOTEL PFISTER/Imperial Ballroom

This luncheon is open to all members of the Society, their spouses, and other guests.
It will feature an outstanding authority speaking on a medical socio-economic topic of great interest to Wisconsin physicians.

WISCONSIN ACADEMY OF FAMILY PHYSICIANS

Meeting and Luncheon

Sunday, March 25—11 am

Hotel Pfister/Henry VIII & Louis XIV Rooms

AN ANNUAL MEETING ASSOCIATED FUNCTION

Southeastern Wisconsin Cancer Conference

Earlier Cancer Detection

PROGRAM

SATURDAY, MARCH 24

9:15 am to 12:30 pm

HOTEL PFISTER/Imperial Ballroom

9:15 WILLIAM M. CHRISTOPHERSON, MD, Pathologist; Professor and Chairman, Department of Pathology, University of Louisville School of Medicine, Louisville, Ky.
The Long Term Effects of Uterine Cancer Control

9:45 GERALD D. DODD, JR., MD, Professor and Chairman, Department of Radiology, University of Texas M. D. Anderson Hospital and Tumor Institute
Thermography and Mammography as Diagnostic Aids

10:15 Coffee Break

10:30 ROBERT V. HUTTER, MD, Pathologist; American Cancer Society—New Jersey Division; Professor of Oncology, Harrison S. Maryland Hospital, Newark, N. J.
Early and Marginal Breast Cancer

11:00 JACK W. COLE, MD, Surgeon; Professor and Chairman, Department of Surgery, Yale University School of Medicine, New Haven, Conn.

11:30 ARTHUR I. HOLLEB, MD, Surgeon; American Cancer Society, Senior Vice President for Medical Affairs and Research, New York, N. Y.

12:00 Panel Discussion—Joseph F. Kuzma, MD, Moderator

FOLLOWED BY LUNCHEON IN THE HALL OF PRESIDENTS, HOTEL PFISTER

ASSOCIATED EVENTS

Monday, March 26—5:00 pm

HOTEL PFISTER

Business meetings of the

WISCONSIN ALLERGY SOCIETY
SECTION ON INTERNAL MEDICINE
SECTION ON PUBLIC HEALTH

• • •

Monday, March 26—6:30 pm

HOTEL PFISTER

President's Reception
followed by
Public Affairs Dinner

• • •

Tuesday, March 27—6:30 pm

Milwaukee Athletic Club

WISCONSIN SURGICAL SOCIETY
(By invitation only)

• • •

Tuesday, March 27—6:00 pm

Milwaukee Athletic Club

WISCONSIN ORTHOPEDIC SOCIETY
(members only)
Speaker: PAUL H. CURTISS, JR., MD
Columbus, Ohio
Presentation: *Fractures of the Shaft of the Femur in Children*

• • •

Tuesday, March 27—6:00 pm

University Club of Milwaukee

MILWAUKEE OPHTHALMOLOGICAL SOCIETY
Dinner and Program
(all ophthalmologists and interested physicians welcome)
Speaker: CHARLES E. ILIFF, MD
Baltimore, Md.
Presentation: Surgeon's *Approach to Ptosis*

• • •

Tuesday, March 27—6:00 pm

Marriott Motor Inn—Brookfield

WISCONSIN RADIOLOGICAL SOCIETY
Dinner and Program

Medicine and Religion
BREAKFAST

sponsored by the State Medical Society's Committee on Medicine and Religion and the Catholic Physicians Guild

Monday, March 26—7:30 am

HOTEL PFISTER

Speaker: *Rev. Robert F. McEniry, SJ*
Dept. of Philosophy, Creighton Univ., Omaha

Discussion of encounter groups and their relationships to medical practice.

74 Wisconsin Physicians and Guests

have been invited to speak at the request of the Commission on Scientific Medicine to carry out the theme of the Annual Meeting: "Evaluation and Therapy of Common Endocrine Disorders."

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

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Dean, Medical College of Wisconsin

HENRY C. PITOT, MD _____Madison
Acting Dean, University of Wisconsin Medical School

VICTOR S. FALK, MD _____Edgerton
Medical Editor: *The Wisconsin Medical Journal*

RESERVATION FORMS FOR

Noon Luncheons • Public Affairs Dinner

NOTE: Attendance Limited! Please list 2 choices, in order of preference, for the section luncheons on Tuesday, March 27. $5.00 per luncheon, including gratuities and taxes.

MONDAY, MARCH 26—Socio-economic Luncheon

This luncheon will be open to all members of the State Medical Society and will feature a distinguished speaker.

TUESDAY, MARCH 27—Section Luncheons

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ANESTHESIA: Luncheon speaker—*Theodore C. Smith, MD,* Philadelphia. Followed by afternoon program.
2. OB–GYN: Wisconsin Section, District VI of ACOG. Film—"Colposcopy." Followed by afternoon program.
3. OPHTHALMOLOGY: Luncheon. No speaker. Followed by business meeting and afternoon program.
4. ORTHOPEDICS: "The Dilemma of Osteosarcoma," by *Paul H. Curtiss, Jr., MD,* Columbus, Ohio. Followed by afternoon program.
5. OTOLARYNGOLOGY: Luncheon. No speaker. Followed by afternoon program.
6. PATHOLOGY: "Adrenal Cortex," by *Sheldon C. Sommers, MD,* New York City.
7. RADIOLOGY: "Radiology of Portal Hypertension," by *Francis F. Ruzicka, MD,* New York City.
8. WISCONSIN COMMITTEE ON TRAUMA: American College of Surgeons.
9. PLASTIC SURGERY: Luncheon.

First Choice: _____ Second Choice: _____
(Name of Section or Leader) (Name of Section or Leader)

MONDAY, MARCH 26—Public Affairs Dinner

Featuring a nationally prominent speaker. $12.00 per person (including gratuities and taxes).

Number Luncheon Tickets ($5.00 each) . . . _____ for $ _____

Number Public Affairs Dinner Tickets ($12.00 each) for $ _____ Total: $ _____

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Clinical Staging and Lymphography in Hodgkin's Disease

RONALD L. VAN ROY, MD
GEORGE W. WIRTANEN, MD
Madison, Wisconsin

One hundred thirty-four lower extremity lymphograms were compared with initial clinical staging in Hodgkin's disease. Thirty-one percent of the patients were clinically understaged in Stage II prior to the lymphogram. Eight of 56 Stage III patients and nine of 33 Stage IV patients had normal lymphographic studies. Fifty-one percent (44/87) of the patients in substage A and 68% (32/47) of the patients in substage B had abnormal lymphograms. Lymphography is useful in evaluating the patient with Hodgkin's disease in directing surgical biopsy, in outlining treatment fields for the radiotherapist, and in opacifying nodes for extended time intervals so that the radiotherapist and chemotherapist may not only evaluate the effectiveness of their therapy, but may also quickly recognize tumor activation.

STAGING IN HODGKIN'S disease is important to deliver adequate high dose supervoltage radiotherapy,[1] with or without chemotherapeutic combinations of drugs,[2,3] to increase patient survival and cure.[4] The patient's history, physical examination, chemical, roentgenographic, including lymphography,[5-8] surgical[9-11] including liver biopsy, node biopsies, bone marrow aspiration or biopsy, and splenectomy, and histologic evaluation[12,13] are all integral parts of a thorough evaluation.[14]

Methods and Materials

One hundred thirty-four consecutive bilateral lower extremity lymphograms of patients with Hodgkin's disease were reviewed. Lymphography was done as described previously.[15,16] The patients were staged clinically prior to lymphography. The final statistics are related to the patient's stage, according to the Rye Classification,[17] after complete examination including lymphography with associated roentgenograms and surgical biopsies without laparotomy.

From the Division of Radiotherapy, Department of Radiology, University of Wisconsin Medical School, Madison.
Supported in part by National Cancer Institute, Public Health Service Grant 5 P02-CA-06295-RAD.
Reprint requests to: Ronald L. Van Roy, MD, Division of Radiotherapy, UW Medical School, 1300 University Ave., Madison, Wis. 53706.
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All of the lymphograms in these patients were done bilaterally, except for a unilateral lower extremity examination in one patient. Insufficient contrast was introduced intralymphatically in a three-year-old child to opacify the nodes for adequate nodal evaluation, and this patient is not included in these statistics.

Results

Review of the lymphographic findings in the 134 patients with Hodgkin's disease demonstrated that 57% (76/134) had abnormal lymphograms. Fifty-one percent (44/87), who were staged in substage A and 68% (32/47) of patients who had been in substage B, had positive findings.

The clinical staging was compared with the lymphographic staging, and the lymphographic study changed the clinical staging in 31% of the patients (42/134). The staging was decreased in one patient from Stage IIIB to IIB, verified at laparotomy, and in 41 patients, the staging was increased, 34 patients advancing to Stage III, and 7 patients to Stage IV. All of whom had been clinically Stage II Hodgkin's (Table 1).

The seven patients advancing to Stage IV comprised two distinct groups. Four of the seven patients advanced to Stage III on the basis of the lymphogram and to Stage IV on the basis of surgical exploration which demonstrated extra nodal involvement. The other three patients had extra nodal involvement found incidentally on the lymphogram films, two with bone involvement (Fig 1) and one with pulmonary involvement.

Figure 1—This patient had a bilateral lower extremity lymphogram, and this 24-hour film demonstrates lymphomatous nodes in the iliac and periaortic chains bilaterally. The pedicles of L3 are sclerotic.

The final staging in this group of patients is summarized in Table 2 and includes 12 patients in Stage I, 34 patients in Stage II, 56 patients in Stage III, and 33 patients in Stage IV.

There was one positive lymphogram in a Stage I patient (1/12), positive in the inguinal area. All other Stage I patients had involvement above the diaphragm. Four of the Stage II patients had positive lymphograms, 12% (4/34), one was positive in the left supraclavicular area, two had positive abdominal nodes, and one patient had a false positive study, found to be negative on laparotomy.

Eight of 56 Stage III patients had normal lymphograms with positive surgical explorations, the patients becoming Stage III on the basis of involvement of the spleen, or by virtue of involvement of other than inguinal, iliac and periaortic nodes, such as mesenteric, perisplenic, or prehepatic nodes which do not opacify with this study.

There were nine equivocal lymphograms all of which were included in the negative group for statistics, two of which at laparotomy were found to be positive, and two to be negative in the area of opacified nodes, although one patient had splenic involvement, and the other had positive celiac nodes.

Eighty-one patients (60%) were male and 53 (40%) female. Twenty-eight percent had the first area of known involvement in the left cervical region,[18,19] 24% had the first area of known involvement in the right cervical area, and 15% had the first area of involvement in the left supraclavicular region. The age range was from 4 to 69 years, with an average age of 35 years.

Sixty-two percent had histologic classifications according to Lukes and Butler.[20] Nine percent of these had lymphocytic predominance, 52% had mixed cellularity, 33% had nodular sclerosing, and 6% had lymphocytic depletion.

Twenty-seven percent (9/33) of the Stage IV patients had normal lymphograms, emphasizing the fact that extranodal involvement can and does occur without diffuse nodal involvement. This finding supports the need for an extranodal staging classification in Hodgkin's disease.[21]

Although all patients had histologically confirmed Hodgkin's disease, all nodal areas were obviously not examined by biopsy in every patient. Eighteen patients underwent laparotomy, one had exploratory thoracotomy and two patients had postmortem examinations. There was one false positive study in this series, and two false negative studies both from the group of nine patients who had equivocal lymphographic findings. This correlation is comparable to other series.[22-26]

Discussion

Lymphography is a valuable procedure with minimal morbidity in determining tumor extent (Fig 2).[16,27-32] It allows for directed biopsy in order to histologically evaluate abnormal-appearing nodes on lymphographic study,[9-11] and directs the inclusion of all abnormal nodal areas into the radiation treatment field. Response to therapy may be evaluated by decrease in nodal size, and a decrease in the field size, with reduction in tumor mass and allows for normal tissue sparing in areas of radiosensitive structures such as the kidneys.[33] Serial follow-up films of both treated and untreated nodes may be obtained for many months following the procedure, since the opacified nodes retain contrast material, to effectively evaluate these nodes for signs of tumor reactivation so therapy may be instituted earlier in these areas than if more conventional diagnostic modalities were employed (Fig 3).

TABLE 1—*Patient staging*

	Initial Clinical Stage	Final Stage	% Change
Stage I	12	12	0
Stage II	74	34	54 (40/74)
Stage III	23	56	144 (33/23)
Stage IV	26	33	27 (7/26)

TABLE 2

Stage (Final)	I		II		III		IV	
	A	B	A	B	A	B	A	B
Lymphogram								
Positive	1		4		32	16	7	16
Changed Staging				1	24	10	3	4
Negative	11		25	5	5	3	2	7
Subtotal	12	0	29	5	37	19	9	23
TOTAL	12		34		56		32	

Figure 2—(A) This demonstrates foamy appearing lymphomatous nodes in the left iliac, left periaortic, and right periaortic areas at the level of L1–L2. The remainder of the right periaortic and right iliac nodes are normal in appearance. These nodes are seen well in the left posterior oblique projection (B).

Figure 3—This patient with Stage II-A Hodgkin's disease had a normal lymphogram at the time of mantle radiotherapy (A). Two months later (B), the periaortic nodes have enlarged and are positive. Following laparotomy and splenectomy (C) clips mark the positive periaortic nodes and the sites of the ovaries following oopheroplexy, for more effective radiation shielding.

Hodgkin's disease tends to be clinically understaged, and 41 patients in this study staged as Stage II subsequently advanced to Stage III and Stage IV, increasing the percentage of patients in these two stages by 144% and 27%, respectively, and reducing the clinically staged Stage II group patients by 54% (Table 1).

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Carcinosarcoma of the uterus is a rare and lethal disease. Several series of cases have been reported with no five-year survivals, and ten-year survivals are indeed rare. This patient has survived 11 years since her total hysterectomy with bilateral salpingo-oophorectomy, which is the treatment of choice in this disease. She subsequently has developed two apparently unrelated malignancies. One of these was an adenocarcinoma of the rectum, which was treated by abdomino-perineal resection, and the other a recurring spindle cell squamous carcinoma of the skin of her forearm. The patient's survival is not attributed to special surgical technique but rather to the fact that she has always sought prompt medical attention and that her family physician acted promptly. The polypoid nature of her original tumor and the finding of only superficial invasion are also factors in her survival.

Carcinosarcoma of the Uterus

Report of a Case Surviving Eleven Years

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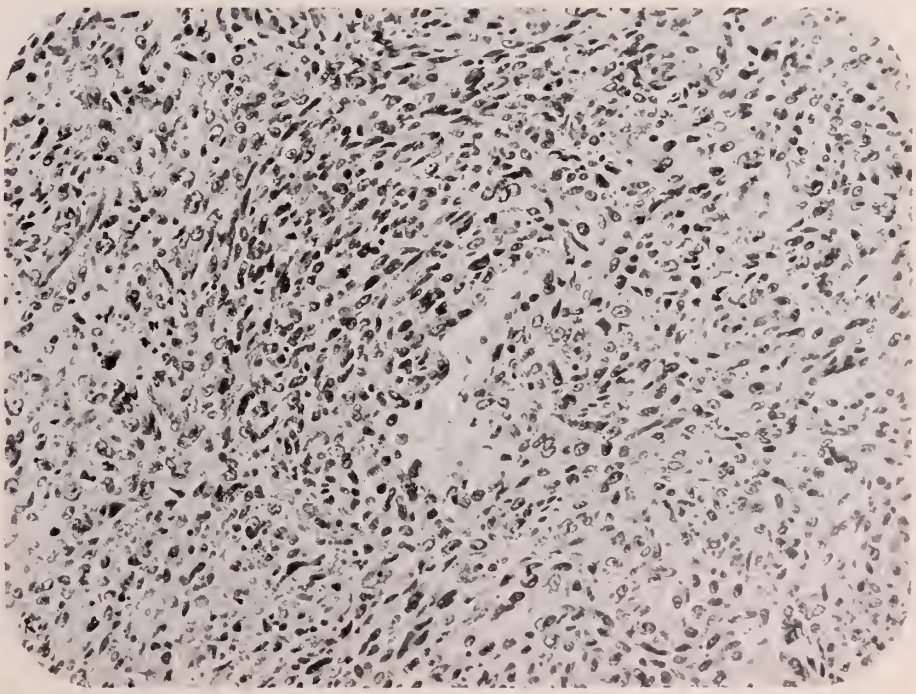
Edgerton, Wisconsin

CARCINOSARCOMA of the uterus is a rare malignant tumor of the endometrium containing both carcinomatous and sarcomatous elements. It is now generally agreed that this is a real entity and not merely a collision of two separate tumors. It has been concluded from tissue culture that there are two distinct cell types without intermediate cell types or evidence of transition from one form to the other. The tumor grows rapidly and is lethal. Almost all of the patients reported in the literature had passed their menopause and were over 50 years of age before symptoms appeared. Most occurred between 55 and 65 years of age. Some of the patients had received intrauterine radium for functional uterine bleeding or some benign condition, usually ten or more years before the diagnosis of carcinosarcoma was made.

The symptoms of carcinosarcoma of the uterus are irregular vaginal bleeding, sometimes preceded by a vaginal discharge. In some cases bleeding may be profuse. The source of bleeding is the polypoid mass attached to the endometrium, which may protrude from the cervical os into the vagina, or even outside of the vagina. The tissue is usually friable and necrotic and bleeds profusely on manipulation.

Metastasis, which is usually hematogenous, may be either as a carcinoma, a sarcoma, or rarely, a com-

Figure 1 (X165)—Pleomorphic spindle cell pattern of tumor with nondescript spaces.



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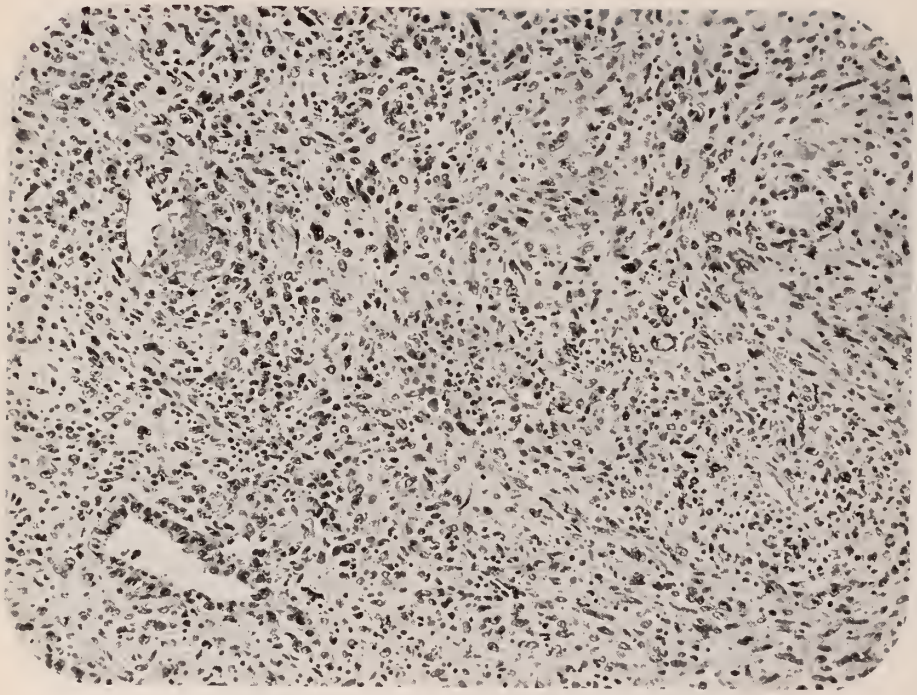


Figure 2 (X120)—Definite glandular or tubular formations of atypical character deriving from the sarcomatous background of pleomorphic cells.

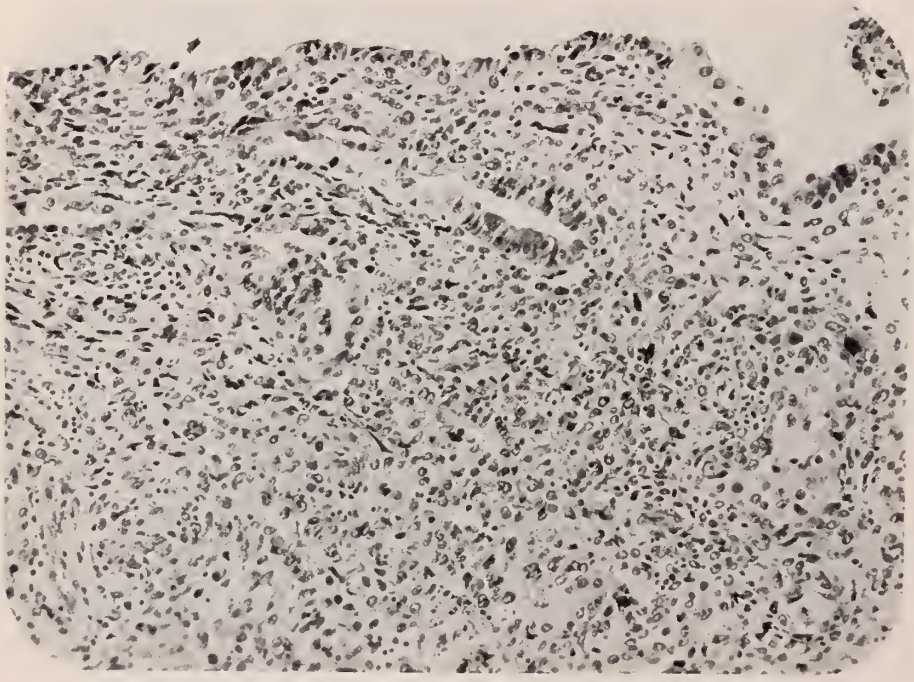


Figure 3 (X150)—Intimate transitions between cells of sarcomatous nature and others of epithelial character forming glandular units.

bination of both. Local recurrence and regional metastasis involving the bladder, parametrium, vagina and perineum are frequent, but lymph node metastasis is infrequent. Metastasis to peritoneum, mesentery, liver, lungs and pleura is not uncommon.

The treatment of choice for carcinosarcoma of the uterus is early total hysterectomy and bilateral salpingo-oophorectomy. The role of preoperative radiation therapy is uncertain, but it may be important as primary treatment to improve survival. However, postoperative irradiation for patients with metastasis should certainly be considered, particularly since the metastasis might be pure carcinoma.

The prognosis is so poor that the average survival is 6 to 12 months after the diagnosis is established. A 50-year review of 32 cases from the Columbia Presbyterian Medical Center[1] reported no five-year survivors. There were also no five-year survivors in 21 cases reported from New Orleans Charity Hospital,[2] the longest survivor living 27 months after the appearance of symptoms. Other isolated case reports have shown one case of nine-year survival and another of ten years. Doctor Malcolm B. Dockerty of the Mayo Clinic, in a personal communication to the author, reported one patient who died at age 80, 19 years after her pelvic surgery.[3] Although the prognosis is poor, there may be an indication for preoperative intracavity irradiation as shown by the M.D. Anderson Tumor Institute.[4] Where this form of therapy was utilized, the

five-year survival for sarcomas of the corpus increased from 15.9% to 42.8%.

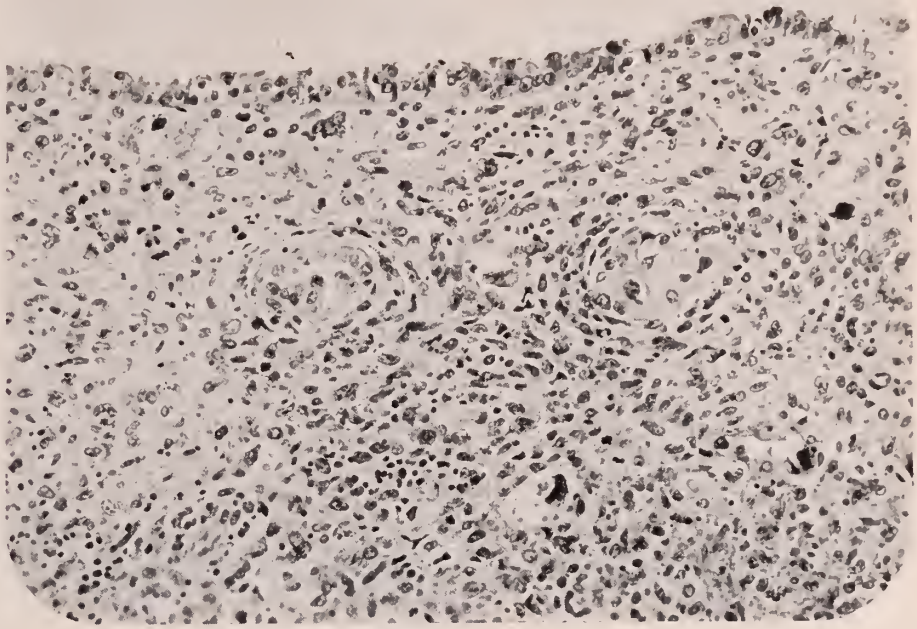
The purpose of this paper is to present a single case of carcinosarcoma of the uterus which is unusual because of the patient's 11-year survival and the appearance of two additional apparently unrelated malignancies in the same patient.

Case Report

Eleven years ago this patient noted spotting for a day or two following some rather strenuous work. This recurred about two weeks later and she then reported to her family physician. She was 64 years of age, her last menstrual period had been twelve years before and her menopause was reported as uneventful. She had had four pregnancies, including one stillbirth and one miscarriage. A sister was reported to have died of carcinoma of the cervix five years before. The history did not relate any other familial malignancies. The patient had no other complaints and had had no weight loss. Smears were made from the cervix and vagina and the exfoliative cytology report was positive for the presence of malignant cells.

The patient was hospitalized promptly (April, 1961), and dilatation and curettage produced a relatively large amount of tissue. The pathological diagnosis was carcinosarcoma of the uterine endometrium. (This, too, is somewhat unusual, as the exact diagnosis of carcinosarcoma is not often established with the tissue obtained by D & C.) Within a few days the patient had laparotomy with total hysterectomy and bilateral salpingo-oophorectomy. The uterus was found to be smooth and only slightly enlarged. There was no gross evidence of metastasis. Upon opening the uterus, a polypoid mass measuring 6 x 4 x 3 cm was found to be arising from the anterior wall. The mass had a broad base measuring 4 x 2 cm.

Microscopic examination of the lesion showed it to have a spindle cell sarcomatous pattern with considerable irregularity of nuclei including numerous neoplastic giant cells and abnormal mitoses. There were no rhabdomyoblasts or other mesenchymal elements present. In and intimately associated with this tissue were atypical glandular units lined



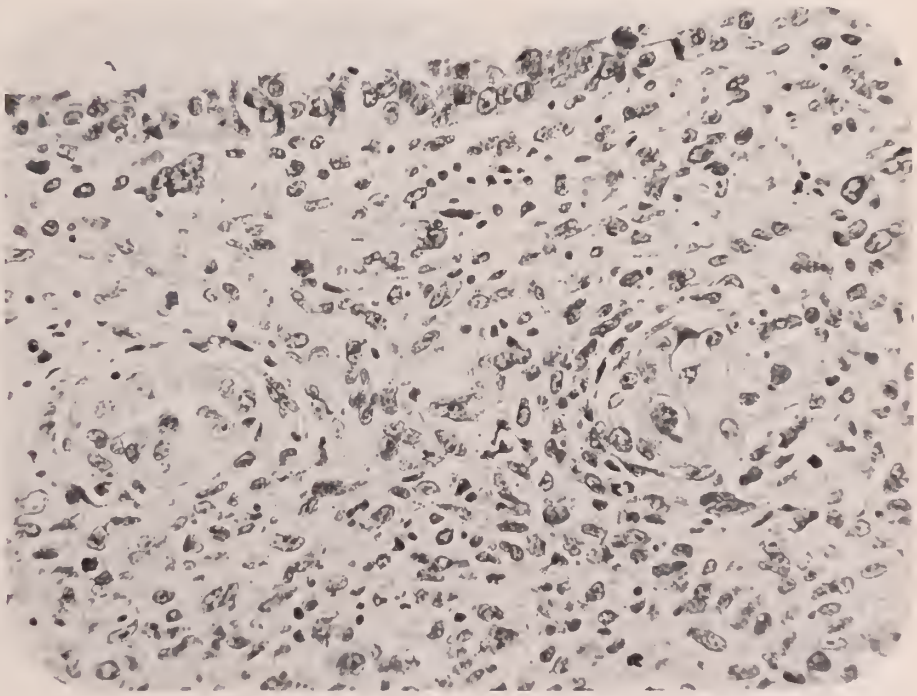


Figure 4 (X160) and 5 (X250)—Well structured glandular units and squamous cell nests of neoplastic qualities in an otherwise solid pleomorphic cell sarcomatous tumor.

by one or more layers of anaplastic epithelial cells in places showing squamous differentiation. The lesion infiltrated the myometrium only very superficially, but a few underlying endothelial lined spaces contained tumor tissue.

The patient's postoperative course was uncomplicated and she was followed closely for the next five years. Repeated vaginal smears were negative for malignant cells and there was no evidence of any recurrence or metastasis. However, in 1966 (more than five years after hysterectomy), she again consulted her family physician because of "bleeding hemorrhoids." She had been aware of what she thought were hemorrhoids all her adult life but had noted some blood and mucus in her stools for the preceding month. On examination she was found to have a mass in the rectum. X-ray studies of the colon by barium enema showed no evidence of disease, but biopsy of the rectal mass was reported as infiltrating adenocarcinoma. Soon thereafter she underwent an abdomino-perineal resection with incision of the posterior vaginal wall and liver biopsy. The pathological diagnosis was the same as reported on biopsy. The lymph nodes and liver were free of metastasis. It was the opinion of the pathologist that this second malignancy was unrelated to the carcinosarcoma of the uterus.

Again, her postoperative course was uneventful and periodic followups revealed no evidence of recurrence of either of her two malignancies. However, eight years after the hysterectomy (March, 1969) she was seen because of a lesion on the skin of her right forearm which had been present for about three years. This had not troubled her until it became inflamed and swollen. Following treatment with compresses and antibiotics the lesion was excised. Six months later (November, 1969) a recurrence was excised. In another six months (April, 1970) there was a large recurrence of the tumor of the right forearm. This was widely and deeply excised. After reviewing the sections of all three of the excised tissues, the final conclusion was that this was an infiltrating spindle cell squamous carcinoma of the skin. Following this last excision there again were recurrences in the skin of the forearm which were finally removed chemosurgically. In November, 1972, a lymph node was removed from the right antecubital fossa. The pathological diagnosis was metastatic spindle cell squamous carcinoma.

Summary

A case of a patient with carcinosarcoma of the uterus has been presented. The disease is a rare and lethal one. Several series of cases have been reported with no five-year survivals and ten-year survivals are indeed rare. The patient has survived 11 years since her total hysterectomy with bilateral salpingo-oophorectomy, which is the treatment of choice in this disease. She subsequently has developed two apparently unrelated malignancies. One of these was an adenocarcinoma of the rectum, which was treated by abdomino-perineal resection, and the other has been a recurring spindle cell squamous carcinoma of the skin of her forearm. The patient's survival is not attributed to any special surgical technique but rather to the fact that she has always sought prompt medical attention and that her family physician also acted promptly. The polypoid nature of her original tumor and the finding of only a very superficial invasion are undoubtedly also factors in her survival.

(G. F. Burpee, MD was the patient's primary physician. M. B. Llewellyn, MD was the pathologist.)

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Multiple Lymphoid Polyps in Familial Polyposis

JAMES GRUENBERG, MD and SANFORD MACKMAN, MD, University of Wisconsin Medical Center, Madison, Wis: *Ann Surg* 175:552–554 (Apr) 1972

This case report describes a patient who had multiple lymphoid polyps of the colon and small bowel in a family with known multiple adenomatous colonic polyps. Preoperatively the patient was assumed to have familial polyposis and thus underwent a colectomy and ileostomy. The pathological specimen, however, revealed no adenomatous polyps and was studded throughout with lymphoid polyposis. Management of this patient was discussed from the background of these two entities and a question of their association was raised. □

Snowmobile Accidents in Central Wisconsin

Experience During the 1970-1971 and 1971-1972 Seasons

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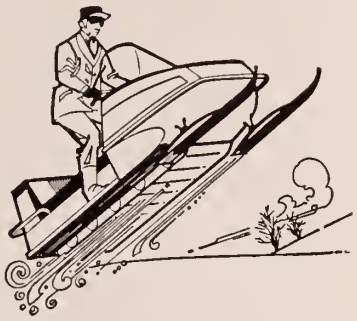

THE USE OF THE SNOWMOBILE for recreational purposes has mushroomed over the past five years and, in the state of Wisconsin, the number of machines has multiplied from an estimated 53,000 in 1968 to 180,000 in 1972.[1] It would appear from scattered studies that the accident rate involving snowmobilers is rising rapidly.[2–6] The continued escalation of this accident rate can present a serious public health problem. In addition to the morbidity and possible mortality related to such accidents, consideration also must be given to the impact on the already over-crowded emergency facilities of both rural and urban hospitals.

Preliminary studies have been carried out to determine the nature of injuries suffered by the snowmobiler. Withington and Hall[7] reported 59 persons involved in snowmobile-related accidents. Their study contained data on circumstances surrounding the accident as well as the type of injury. A number of studies reported in 1972 at the Fourth International Snowmobile Congress in Quebec City, Canada,[8] also provided documentation of the many circumstances surrounding the injuries received through snowmobile accidents. Another recent excellent review of the topic was the work of Mongé and Reuter who reported on 267 individuals injured in a 201-day study of snowmobile accidents.[9] A brief report also appeared in the *Wisconsin Medical Journal* by Kritter, Carnesdale, and Prusinski in which they reported 39 injuries in 1969–1970 and 58 in 1970–1971.[10] Sell[11] in reporting data from the state of Michigan noted that the death rate has increased 130% from 1968 to 1972. Another description of snowmobile injuries was written by our own group stressing the role of the oral surgeon in the treatment of the snowmobile accident victim.[12]

The object of this report is to review the circumstances surrounding snowmobile accidents and the type of injuries suffered by the snowmobiler during the 1970–1971 and 1971–1972 snowmobile seasons in central Wisconsin. The study was undertaken in order to provide more background information for recommendations to improve the safety of this rapidly growing winter sport.

Methods

During the summer of 1970, a questionnaire was developed to provide detailed information on driver experience, driver age, time of day of the accident, size of machine, location of accident, speed, terrain, alcohol intake, cause, site, and treatment of the injuries. This questionnaire was utilized during the winters of 1970–1971 and 1971–1972 and was completed for each snowmobile accident victim seen in the emergency room of St. Joseph's Hospital, Marshfield, Wisconsin. All patients were seen by one of the members of the Department of Oral Surgery. The total number of accident victims for the two seasons was 164, of whom 86 were seen in 1970–1971 and 78 in 1971–1972.

Results

Table 1 shows the age distribution of 126 males and 38 females injured in the two snowmobile seasons. Of the total, one-ninth of the victims were 10 years old or younger. The youngest victim in the entire series was a 2½-year-old thrown from the machine because of rough terrain. The accident rate according to age was similar during both seasons of the study.

Table 2 shows the relationship of driver experience to frequency of accidents. Half of the drivers had experience of one year or less. There was a slight increase in new drivers involved in accidents from 1970–1971 to 1971–1972.

Table 3 lists the place of the accident and demonstrates that the greatest number occurred in open fields rather than in wooded areas. Highways and roadsides rated second during both seasons of the study and there were no statistically, significant differences between the two snowmobiling seasons.

Table 4 shows the causes of the accidents. As expected, collisions with fixed obstacles accounted for the greatest number of injuries. There was a slight decrease in the number of collisions during the second snowmobile season and an increase in the number of individuals hitting fences.

Table 5 shows the snowmobile speed at the time of the accident. More than half of the accidents in the total series occurred at 20 miles per hour or less. Table 6

From the Marshfield Clinic Foundation for Medical Research and Education, the Marshfield Clinic, and St. Joseph's Hospital, Marshfield.
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identifies the protective gear worn by the victims. In the total series, it was estimated than 75% were inadequately protected. Table 7 shows the sites of 189 regional injuries to the 164 patients. More involved the head and neck than any other area of the body. Of the head and neck injuries, 69% were lacerations, abrasions, or contusions; 12% alveolar fractures; 8% facial fractures (including 4 nasal fractures and 4 fractures of zygomaticomaxillary complex); 8% cranial injuries; and 4% eye injuries. Again, there was little difference in the sites of injuries between the two seasons.

Table 8 describes the type and number of injuries in the 164 patients in this series. There were a total of 190 injuries, most of which were lacerations (74), fractures and sprains, and contusions account for the majority of the remaining of the injuries.

Table 9 lists other circumstances surrounding snowmobile injuries during the two seasons. Six percent of the accident victims in 1970–1971 and 8% in 1971–1972 were judged intoxicated by the attending physician. Darkness certainly played a great role in the accident rate and 71% to 74% of the accidents occurred during the nighttime hours. There was a sharp increase from the 1970–1971 to the 1971–1972 season.

The driver was the most frequently injured in snowmobile accidents, as one might expect. However, passengers and bystanders were not immune to snowmobile accidents.

Discussion

The careless use of any type of mechanical device, whether for work or for recreation, can often lead to tragedy. This fact has become quite apparent since the introduction of the snowmobile as a recreational vehicle. In order to focus on the problems involved in snowmobiling accidents, this study was undertaken to provide information for the health professions, snowmobilers, and manufacturers in order to make the sport less hazardous. The study was performed during two consecutive snowmobile seasons to provide a model and baseline data for a long range study of whether changing conditions, the additions of new trails, snowmobile safety

TABLE 1—*Age of patient and number of accidents*

Age of Patient	1970–1971		1971–1972	
	No.	%	No.	%
0 to 10 years	11	13	7	9
11 to 20	26	30	27	35
21 to 30	25	29	32	40
31 to 40	16	19	6	8
41 or more years	8	9	6	8
TOTAL	86	100%	78	100%

TABLE 2—*Driver experience and number of accidents*

Driver Experience	1970–1971		1971–1972	
	No.	%	No.	%
1 yr. or less	39	45	43	55
2 to 3 years	33	38	26	34
4 to 5 years	9	11	5	6
6 yrs. or more	5	6	4	5
TOTAL	86	100%	78	100%

TABLE 3—*Place and number of accidents*

Place	1970–1971		1971–1972	
	No.	%	No.	%
Open fields	39	45	45	58
Highways and Roadsides	20	24	17	22
Backyard	15	17	7	9
Woodlands	9	11	8	10
Racetrack	3	3	1	1
TOTAL	86	100%	78	100%

TABLE 4—*Causes and number of accidents*

Causes	1970–1971		1971–1972	
	No.	%	No.	%
Collision	33	39	20	26
Jump or bump	14	16	13	16
Roll-over	9	10	8	10
Hit fence	7	8	10	13
Fell off	7	8	8	10
Foot out	3	4	3	4
Other	13	15	16	21
TOTAL	86	100%	78	100%

TABLE 5—*Snowmobile speed and number of accidents*

Speed (mph)	1970–1971		1971–1972	
	No.	%	No.	%
0 to 10	35	41	31	40
11 to 20	18	21	17	22
21 to 30	14	16	13	16
31 to 60	19	22	17	22
TOTAL	86	100%	78	100%

TABLE 6—*Protective gear worn by patients*

Protection	1970–1971		1971–1972	
	No.	%	No.	%
No protection	26	30	15	19
Snowmobile suit, goggles, and helmet	14	16	27	35
Snowmobile suit only	26	30	12	15
Snowmobile suit and helmet	3	3	15	19
Snowmobile suit and goggles	9	11	4	5
Goggles and helmet	3	3	4	5
Helmet only	4	5	1	1
Goggles only	1	1	0	0
TOTAL	86	99%	78	99%

TABLE 7—*Site and number of injured regions*

Site of Injury	1970–1971		1971–1972	
	No.	%	No.	%
Head and neck	43	45	37	40
Lower extremity	24	25	34	36
Upper extremity	20	22	18	19
Spine	4	4	1	1
Chest	4	4	4	4
TOTAL	95*	100%	94*	100%

* More than one injured region in some patients.

TABLE 8—*Type and number of injuries to 164 patients*

Type	Number of Injuries
Laceration	74
Fracture	42
Sprain and Contusion	46
Internal Injury	4
Concussion	5
Other	19
TOTAL	190

programs, and legislation can have any effect on the frequency and severity of snowmobile accidents. There is little difference in the data between the two years thus providing a good base line at a time when the public, manufacturers, and legislators are becoming more aware of the incipient danger related to snowmobiling.

Age certainly appears to be a factor in our experience in central Wisconsin. Withington and Hall reported 3 patients (5.1%) in the 0 to 10 year age group out of 59 persons involved in accidents.[7] In our composite of 164 patients, 11% were 10 years old or less. Studies by Dr. J. W. Martin of Peterborough, Ontario, also showed 8% of injuries in the first decade of life.[8] Obviously legislation should be developed to regulate the minimum age and to require the supervision of youthful drivers. This legislation has been passed in Wisconsin, and time will tell whether its enforcement will be possible.

Driver experience also seems to be an important factor. None of the published studies have looked at this particular point, but it would appear that snowmobile training and safety programs should be conducted in order to acquaint the snowmobiler with the potential dangers involved in the sport. Nearly half of the accident victims had one year or less operating experience and the accident rate dropped rapidly with the more experienced drivers. There is little question that this fact would point towards extensive snowmobile safety training programs which are now underway in Wisconsin.

Speed and control of the machine centainly have been factors and have been alluded to in a number of studies. However, it is important to note that significant injury can occur while the vehicle is moving slowly. It also should be considered that, as racing becomes a more popular sport, there will be an increase in injuries resulting from accidents on the track. One such driver in this series was thrown from his machine and his leg extensively injured by the lugs

in the racing treads of a following machine. Another race-track accident involved a head-on collision during the practice session in which both drivers suffered severe head and neck injuries.

Although one would expect accidents to occur most frequently in wooded areas, this has not been our experience nor the experience of others. Open fields are more hazardous because of snow covered obstacles, barbed wire fences and other situations in which serious accidents can occur. The only contradiction to this is a study by Mr. Pierre Yves Dionne[9] who reported on 46 fatal accidents, 21 of which occurred on secondary roads, 12 on other roads, 4 on railroad tracks, and 4 in lakes and rivers, which might indicate that most accidents take place on roads. These were *fatalities,* however, and did not provide information on the usual *injuries* suffered by the snowmobiler. In our study, highways and roadsides, although significant, with only one exception did not seem to provide an occasion for collision with other motor vehicles. The most frequent cause of accidents in these situations was an unexpected drop or a collision with a culvert or bridge abutment.

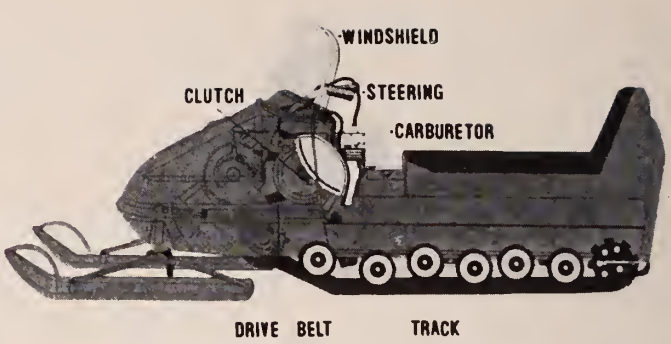

Figure 1—Mechanical source of injury.

The machine itself also can be a significant source of injury; Figure 1 shows the parts of the vehicle most frequently associated with injury. Modification and design improvements to cover these areas could provide more adequate protection. Initial discussion with several snowmobile distributors indicates that at least two of the areas of the snowmobile have been protected by padding and covering parts associated with injury.

In the early days of snowmobiling it was predicted that there would be a great number of spinal injuries. Only 4 of the 164 injuries involved the spine. The greatest incidence of injuries involved the head and neck and these injuries included lacerations and contusions, most of which would have been prevented by proper protective attire. In fact, an estimated one-third of all injuries in this study could have been prevented by the use of adequate protective attire. Injuries to the head, neck, and upper extremities were due primarily to collision. Lacerations from barbed wire fences were particularly significant, and Figure 2 shows such an injury. The incidence of fractures also was significant (Table 7), and the fractures were severe (Fig 3).

Other circumstances that were studied included excessive alcohol intake, which did not appear to be a great factor in the accidents reported in this series. Nineteen patients were adjudged by the examining physician to have had excessive alcohol intake, although objective evidence obtained by blood alcohol levels was not obtained.

Poor lighting seems to be a very significant factor, the majority of the accidents taking place during the hours of darkness. Darkness coupled with poor lighting from the machine itself reduces vision considerably and contributes par-

TABLE 9—*Other data related to snowmobile accidents*

Related Data	1970–1971		1971–1972	
	No.	%	No.	%
Excessive alcohol				
Yes	9	10	6	8
No	77	90	72	92
TOTAL	86	100%	78	100%
Time				
Darkness	61	71	58	74
Daylight	25	29	20	26
TOTAL	86	100%	78	100%
Position				
Driver	60	70	63	81
Passenger	24	28	15	19
Bystander	2	2	0	0
TOTAL	86	100%	78	100%
Hospitalized?				
Yes	24	30	23	29
No	62	70	55	71
TOTAL	86	100%	78	100%

Figure 2—Severe neck lacerations. Man, 34 years old, drove 40 mph in open field at night (1:30 a.m.) and collided with barbed-wire fence.

Figure 3—Severe laceration (left) and compound fracture of fibula and tibia (right). Driver "spun out" during snowmobile race and was hit by another machine.

ticularly to the incidence of collision. More than likely the greatest reason for the nighttime accidents is "over-driving" the headlight by the snowmobiler. It is also interesting to note that most of the accidents took place at relatively slow speeds in open fields and during the evening and night hours. Perhaps better lighting on the machine itself could significantly reduce injuries from this cause. Education of the snowmobilers as to the speed with which a machine can be driven at night would also be an important factor.

Passengers as well as drivers are subject to snowmobile injury. It appears that they are most frequently thrown from the machine by rough terrain or collision with immovable objects. Pedestrians, too, can be involved in snowmobile accidents. Four in this particular study were run over by machines handled by inexperienced operators. A number of the victims were hospitalized. Their average stay was 13.5 days, and the range was 2 to 97 days. This again contributes to hospital utilization and increased activity in the emergency rooms of rural and urban hospitals, facts which continue to increase the cost of care for patients with other illnesses.

The cause of the injury was most often due to collision with a fixed object caused by poor visibility and/or driver inexperience. Jumps or bumps also caused a significant number of injuries in this series. There was a total of 19 roll-overs; 15 vehicles hit fences; 15 drivers fell off; and 7 drivers injured feet while on the machine. One accident victim had her scarf caught in the clutch but was saved from severe injury or death when the machine stalled. No cases of frostbite were seen in this entire series. There was one death; a six-year-old girl on a toboggan was run over and fatally injured. The driver of the machine was her seven-year-old brother. During the 1970–71 season there were 13 deaths in the state of Wisconsin, and in 1971–1972 there were 26 deaths, a 100% increase.[13]

Data from the most recent studies by Mongé and Reuter[9] and Sell[11] and the data shown above agree in almost all details. These authors also call attention to the need for more studies and suggest recommendations for snowmobile safety.

It is apparent from this study that the majority of snowmobile accidents are related to rough and unfamiliar terrain, poor visibility, inexperienced drivers, lack of protection, and snowmobile design. Therefore, the following recommendations are offered to make snowmobiling a safe sport, recreation, or livelihood.

1. Snowmobile training and safety programs should be conducted throughout the state.
2. Helmet, face shield, and snowmobile suits should be worn at all times. One-third of the injuries could have been prevented by the use of adequate driver protection.
3. Legislation should be developed to regulate minimum age and require supervision of youthful drivers.
4. Snowmobiles should be designed for greater safety by covering protruding and moving parts.

5. A better head lamp should be developed to improve vision.
6. Accidents on rough and unfamiliar terrain might be prevented by more and better snowmobile trails.

The state of Wisconsin has taken cognizance of the problem and passed legislation in the most recent session of the Legislature. In that legislation, snowmobile safety and training programs are stressed, youthful drivers are regulated, and funds have been appropriated for the development of snowmobile trails throughout the state of Wisconsin. However, the legislation will be subject to revision to meet the needs in this rapidly changing area. For that purpose the Snowmobile Recreational Council was created through legislation to advise the Governor and the Legislature on further improvements to make the sport safe.

Summary

In central Wisconsin during the winters of 1970–1971 and 1971–1972, 164 individuals suffered significant injuries in snowmobile accidents. Most of these injuries occurred in the region of the head and neck. One-ninth of the victims were 10 years old or younger. About one-half of the accidents involved drivers with less than one year of snowmobile experience. Almost one-third of the victims wore no protective gear such as snowmobile suits, goggles or helmets. Spinal compression was infrequent and one death occurred in this series. Recommendations for making the sport safer are presented.

ACKNOWLEDGMENTS: The authors are indebted to Mr. Robert Payne and the emergency room staff of St. Joseph's Hospital, and to Mr. Roger Harter and the Medical Arts Department. We are also indebted to Mr. Albert Zimmermann for his assistance in editing.

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Status Epilepticus of Late Adult Onset

GASTONE G CELESIA, MD; BERNARD MESSERT, MD; M JOHN MURPHY, MD, Madison, Wis: *Neurology* 22:1047–10SS (Oct) 1972

Seventeen cases of status epilepticus occurring after the age of 40 are described. In 14 cases the epilepsy and status epilepticus were symptomatic. The etiology of symptomatic status epilepticus was vascular in 6 cases, traumatic in 4 cases, neoplastic in 3 cases, and due to multiple sclerosis in 1 case. Thirteen of the 17 cases (76%) of tardive status epilepticus were focal. The focus of epileptogenicity in 71% of cases was in the frontal lobe. Nine of the 14 patients with symptomatic status had more than one disease at the time of onset of status. The presence of multiple diseases may have contributed in precipitating the status and complicated the treatment of these patients. Ten patients died, 3 of unrelated causes. Seven patients (41%) died from the organic cause responsible for the status epilepticus during the first seven months following the onset of the epileptic state. The prognosis of tardive status epilepticus is poor because, unfortunately, anticonvulsants cannot alter the course of underlying neurological disease.

An EEG during status epilepticus was obtained in 7 cases. EEGs are indispensable in case of stupor to establish the diagnosis of status and differentiate between types of status epilepticus. EEG was also most useful in determining the presence of a destructive lesion. A slow wave focus was seen in 9 of the 12 cases (70%) of symptomatic epilepsy recorded. □

Familial Popliteal Cysts in Children

WILLIAM M TOYAMA, MD, Marshfield Clinic, Marshfield, Wis: *Am J Dis Child* 124:S86–S87 (Oct) 1972

Popliteal cyst, "Baker's cyst," is an uncommon but well recognized problem in pediatrics. Although possible inheritance of this disorder has not been described, I report three boys, all first cousins, who presented with typical popliteal cysts. Two boys, 7 and 9 years old, were referred to the Marshfield Clinic at the same time in 1969. Each had a typical popliteal cyst confirmed at surgery. In October 1971 a third child, 3 years old, was operated upon and a similar popliteal cyst was excised.

These three boys were found to be first cousins. No other family members have had any known knee diseases or surgery. This is a large, young family and we plan to follow the children periodically for any future developments of popliteal cysts.

Although one can theorize some hereditary abnormality in the content of bursal or joint fluid, it seems more likely that in children having a familial predisposition, minor repeated trauma leads to formation of a popliteal cyst. All three subjects of this paper had cysts characterized by fibrocystic walls with inflammatory cells or increased vascular proliferation.

In most children, popliteal cyst does not recur following surgical removal. Although many of these childhood cysts are asymptomatic and may be managed conservatively, surgery is dictated in most cases by parental concern about the significant knee mass which persists. We routinely excise all childhood popliteal cysts and have encountered no complications. □

Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Treatment of Hodgkin's Disease: Surgical Role

JAMES M. KENNEY, MD
WILSON WEISEL, MD
Milwaukee, Wisconsin

THE SURGEON'S ROLE in the treatment of Hodgkin's disease has been expanded in recent years with the introduction of staging.[1] The addition of laparotomy, splenectomy, liver biopsies, multiple lymph node biopsies, abnormal tissue biopsy and iliac crest biopsy for more complete assessment of the patient with this lesion has enlarged the surgical scope for care of the patient. A review of this method and its utilization in this hospital for 18 patients in the past three years will be described.

Thomas Hodgkin published a paper in 1832[2] entitled "On Some Morbid Appearances of the Absorbent Glands and Spleen." The name "Hodgkin's disease" was given the disorder in 1865 when Wilks[3] reviewed Hodgkin's 7 cases and added 15 more. Since that time many advancements have been made in the pathologic classification, grading, clinical understanding, and treatment of the problem. With the introduction of staging a method for possible refinement of therapy has been offered and is being evaluated. Current pathologic classifications[4,5] tend to divide the lesion into four types: lymphocyte predominant, nodular sclerosing, mixed cellularity, and lymphocyte deplete.

It has been our opinion that in the prognosis and proper management of the disease accurate staging is of greater value than the histology.

Staging is considered after diagnosis has been established and following a thorough initial evaluation which includes: history and physical examination, clinical laboratory studies evaluating peripheral blood counts and smears, sedimentation rate, alkaline phosphatase, creatinine, blood urea nitrogen, and bromsulphalein; roentgen examinations include thoracic views, intravenous pyelogram, tomography when indicated, liver and spleen scans, and lipiodol lymphangiograms. The performance of laparotomy for staging is best done in a given institution by a limited number of surgeons who are well versed in the disease and are willing to follow approved protocol.

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The technique of staging has been as follows: A laparotomy is performed through a long midline incision. The spleen is removed along with the hilar lymph nodes. Wedge and needle biopsies are made of at least two lobes of the liver. Multiple lymph nodes are removed from the celiac, aortic, iliac, portal, and mesenteric areas. All nodal areas removed are marked with silver clips and all abnormal or questionable nodes on the lymphangiogram are removed. Each group of specimens is submitted separately and specimens clearly labeled as to their abdominal geography. On closing the incision, an iliac crest bone biopsy is taken.

The current staging classification[6] is as follows:

STAGE I—Involvement of a single lymph node region or of a single extralymphatic organ or site.

STAGE II—Involvement of two or more lymphoid regions but limited to one side of the diaphragm.

(a) Subscript indicates the number of regions involved or solitary involvement of an extralymphatic organ or site and of one or more lymph node regions on the same side of the diaphragm. (II–E)

STAGE III—Involvement of lymph node regions on both sides of the diaphragm which may also be accompanied by involvement of the spleen (III–S) or by solitary involvement of an extralymphatic organ or side (III–E) or both (III–SE).

STAGE IV—Multiple or disseminated foci of involvement of one or more extralymphatic organs or tissues, with or without associated lymph node involvement.

(In Hodgkin's disease, all patients are subclassified A or B to indicate the absence or presence, respectively, of documented unexplained fever, night sweats or generalized pruritus.)

The procedure described above has been performed on 18 patients in the past three years. In 12, the stage was unchanged after the procedure but for 6 the staging was advanced. These findings have been similar to those reported from other institutions. There has been no mortality in these cases and little morbidity, and all patients are currently alive. Demonstrative of this group of patients are the following:

Case Reports

Case 1. A 20-year-old, white male university student was admitted to the hospital on April 19, 1970. His chief complaint on admission was lumps on the right side of the neck. A review of his history showed the patient had been well up until three weeks previously, at which time the enlarged cervical nodes had been felt. The patient denied most other symptoms except for some rather vague pruritus of the lower extremities. Physical examination, except for the enlarged nodes in the neck, was within normal limits.

The supraclavicular nodes on the right side were removed the following day, revealing Hodgkin's disease of the lymphocytic predominant type. A lymphangiogram appeared normal. The patient had a staging procedure performed four days later. There appeared to be no involvement of the abdominal lymph nodes, the spleen, or the bone marrow or liver in any of the specimens. Accordingly, the patient was classified as Stage II–A and has received his radiation therapy. He is currently feeling well and is being followed by his physician.

Case 2. A 25-year-old, white, married female, was admitted on March 27, 1972, because of the finding of an anterior mediastinal tumor on routine chest x-ray film. The patient was completely asymptomatic and had no symptomatology. Sixteen months prior to admission she had delivered a normal full-term baby girl.

Clinical studies in the hospital were within normal limits. The x-ray studies, including tomograms, showed a superior mediastinal mass. Two days after admission the patient had a bronchoscopic examination, which was considered normal, except for pressure due to an extrinsic mediastinal mass. An exploration of the mediastinum was performed four days after admission and a large nodular tumor was resected. The initial examination of the tumor suggested a thymoma, but final sections showed the presence of a nodular sclerosing Hodgkin's disease.

The patient had a normal convalescence from the thoracotomy. Following this she had an inferior venogram and intravenous pyelogram, which were considered normal on April 4, 1972. She had a normal lymphangiogram, and abdominal exploration was performed April 11 ,1972, with staging. All of the studies were considered normal within the abdomen. She was treated with radiotherapy to the upper portion of the body with protection of the genital areas. The patient returned to work in August 1972.

Conclusions

Although laparotomy has not been generally accepted,[7] it has been our impression that accurate abdominal staging is critical for proper management and prognosis of this disease. In making decisions for proper therapy, these findings may be most important in improving results as indicated in recent papers.[8,9]

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Stabilizing a Gastrostomy Tube: A Simple, Effective Technique

WILLIAM M TOYAMA, Marshfield Clinic, Marshfield, Wis: *Amer J Surg* 123:743–744 (June) 1972

Adequate stabilization of a gastrostomy tube, particularly in infants and children, prevents erosion of the abdominal wall around the tube and is essential for preventing complications such as leakage, cellulitis, sepsis, inadvertent removal, and migration of the tube.

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Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

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Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

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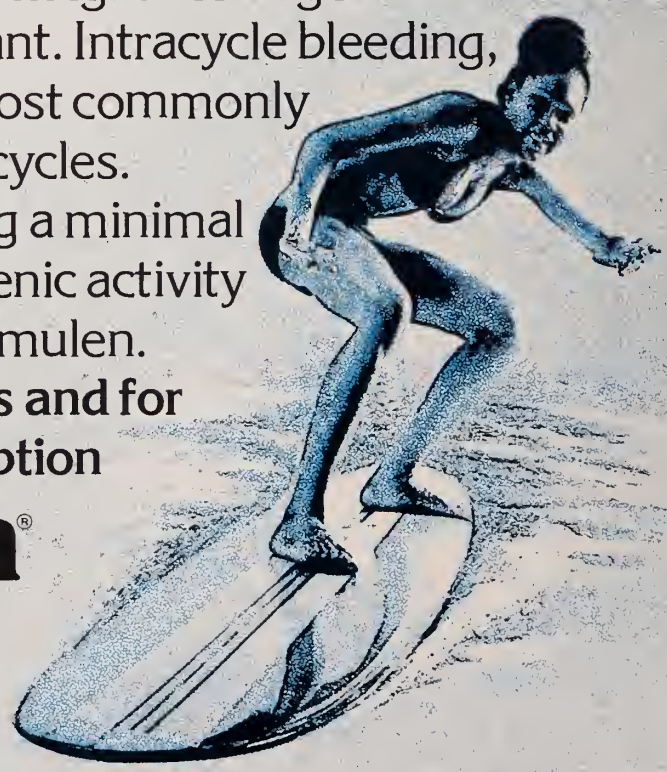

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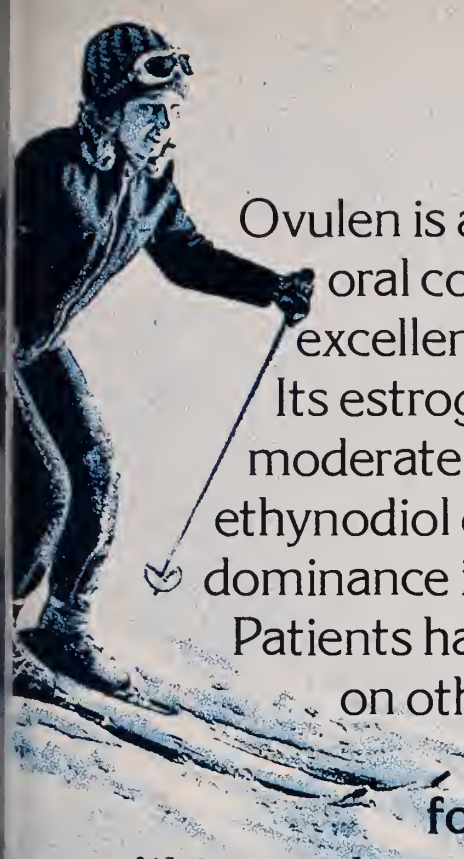
For brief summary of prescribing information, please see next page.



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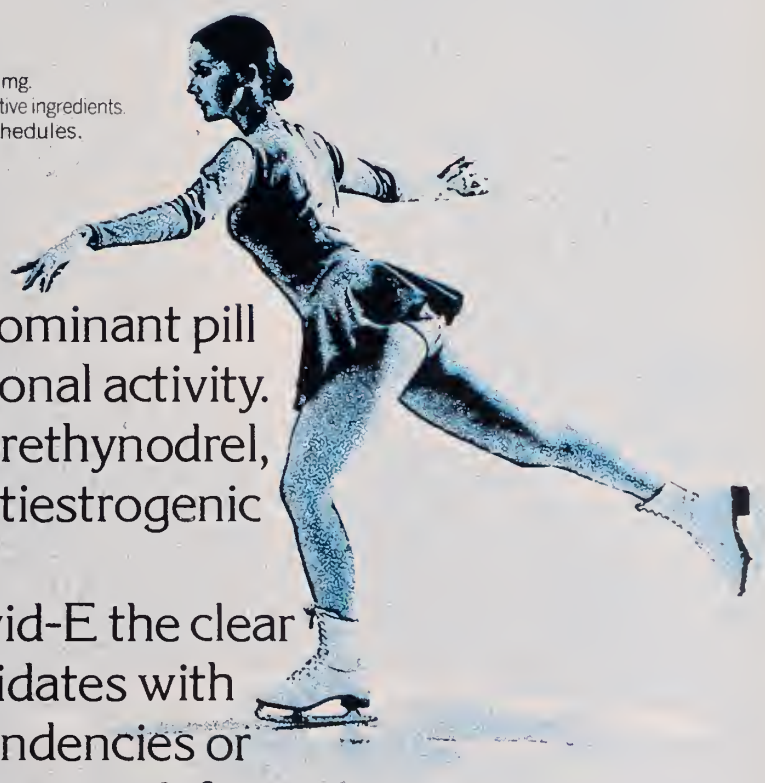

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Actions – Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Ovulen and Demulen are indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function, increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values, metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 196 **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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FOLK MEDICINE and Some Bypassed Therapeutic Measures of Another Day

WILLIAM S. MIDDLETON, MD
Madison, Wisconsin

"Do not condemn or oppose unnecessarily the simple prescriptions of your patients." RUSH

In this admonition Benjamin Rush expressed the wisdom of a vast experience. In a period when empiricism and nosology prevailed in medical practice, he expanded his philosophic approach to an inordinate degree: "Who knows but it may be reserved for America to furnish the world from her productions, with cures for some of those diseases which now elude the power of medicine? Who knows but that, at the foot of the Allegany mountains there blooms a flower that is an infallible cure for the epilepsy? Perhaps on the Monongahela, or the Potowmac, there may grow a root that shall supply by its tonic flowers, the invigorating effects of the savage or military life in the cure of consumption."

Returning to Rush's caution regarding "the simple prescriptions of your patients," there is a natural tendency of physicians to deprecate or reject lay remedies. Yet pharmacodynamics had its humble beginnings in the application of animal or human reactions on the ingestion of herbs. Vomiting and purging were probably the earliest observations from such experiences. These results were extended when natural curiosity and trials introduced opium, quinine and digitalis into medicine. These plant-derived drugs have established their assured position over many years, while lesser agents of similar origin have come and gone. Of singular interest was the philosophy of the signature of plants. The similarity of the leaf, flower or root of a plant to a human organ gave that member a preference in the treatment of the diseases of such a part. Of local interest was the persistence of the belief in China that ginseng root, which resembles the pelvis, genitalia and legs, had a beneficial effect in male impotence and infertility. Wisconsin farmers for years cultivated ginseng for exportation.

Hence folk medicine had an ancient origin. Pliny the Elder (23-79 A.D.) accumulated some 600 products of plant and animal origin for therapeutic use in man. His "Natural History" includes the liver of the wolf with honey for the relief of croup, the brain of the camel for epileptic convulsions and the jawbone of the hyena for chills. Cardinal Richelieu was given a decoction of horse manure in white wine in his terminal illness.

The American public witnessed an impressive revival of interest in this area upon the publication of "Folk Medicine" by DeForest Clinton Jarvis, a physician of Barre, Vermont, in 1958. His message had hundreds of thousands of avid readers. Resolved to essentials, his panacea consisted simply of honey and apple cider vinegar. His homely philosophy obviously had a wide appeal. "Nature opened the first drugstore," he wrote. Continuing he affirmed, "Wherever in the world you were sick, you would find in the fields its medicine to cure you, its materials for cural herbal teas and ointments." Turning to his simple ingredients, he stated. "The vinegar brings across from the apple its mineral content, the honey brings across the minerals in the nectar of the flowers." Expanding his sophistry, he concluded, "Minerals in the soil hitchhike in the vegetation grown in the soil, in order to gain entrance to the body in animals and human beings eating land grown foods." Quite interesting is the description of these remedies by Hippocrates 400 years B.C. The father of medicine used honey with water (hydromel) or with vinegar (oxymel) without the extravagant claims of their modern proponent.

Over the years every physician encounters home remedies in the efficacy of which the layman has great confidence. In many areas of the country and in individuals of every social and intellectual stature the telltale copper wire bracelet or anklet discloses its wearer's subscription to an ancient belief of its potency in preventing arthritis. To the horse-chestnut is ascribed a similar virtue. A physician in West Virginia learned from one of his patients that salt mackerel tied to the soles of the feet prevented arthritis.

The same physician related the following experience: "William Taylor had been bitten by a copperhead snake. Hezekiah Taylor cut a branch from a walnut tree and peeled the bark from it. After incising the skin in three or four places about the bite, the bark was applied locally. Then burning some whiskey in a glass, it was inverted over the area that by this time was quite swollen." Taylor recovered without further manifestations. The physician was at a loss to establish the basis for recovery, incisions, walnut bark, wet cutting or whiskey which had been the first court of appeal!

Respiratory infections are natural targets for home remedies. I should know, for never did I visit my Grandmother Shainline that she did not ply me with

Doctor Middleton is Distinguished Physician, Veterans Administration. Reprint requests to: William S. Middleton, MD, 2114 Adams Street, Madison Wisconsin 53711. Copyright 1973 by the State Medical Society of Wisconsin.

her remedies. How well I remember, "William, take this sulfur and molasses. It will thin your blood." Her favorite remedy for "croup" was a teaspoonful of brown sugar, on which 10 or 20 drops of kerosene had been placed. Turlington's balsam (compound tincture of benzoin) was at times substituted for the kerosene. On occasions the Turlington's balsam was added to a pitcher of boiling water and a towel placed over the head for inhalation in laryngeal or bronchial inflammation. Camphorated oil was used by her for massage on the neck in cervical adenitis attendant on tonsillitis—her expression, "to rub the almonds of the throat." One of the more offensive remedies was suggested to a kinsman by a Pennsylvania German acquaintance. When she indicated that he use duck for a cold, he said, "I did not know that duck meat had any special virtue in colds." Thereupon, she said, "I do not mean duck meat; but the other will cure colds." "What do you mean?", he asked. She responded, "Duck droppings, of course." I do not have the answer to their efficacy. A decoction of elder blossoms in boiling water to which is added borax and sugar, may be sipped or gargled for the relief of quinsy.

The lay expressions of symptoms and other manifestations of disease can be most illuminating. Dr. Charles Henry Bunting spoke of a mother who described her typhoid son as "so unwilling." A patient with hypothyroidism once told me, "My lamp burns very low." A West Virginian described his tremor, thus, "I am so naarvous, I can't sasser my coffee." "Misery in the back" is a frequent complaint among Negroes. "Tettering" was the description of nausea offered by one patient. "Strain" is a common description of urethral discharges in the ignorant. A Wisconsin farmer reported to his physician, "Doc, I have the sugar diabetes." "How do you know that?", the physician asked. The patient answered, "When I piss in the meadow, the cows will not lick it up." It is a common observation that cattle will lap up human urine for its salt content.

Topical applications have a popular appeal from the beginning of recorded history. A patient of mine applied heat to the head for alopecia. When next seen, it was hot salt bags—with equal success! One patient requested milk and bread poultices for the control of edema of the legs. When I later remarked its failure, he indicated that we should have used whole wheat rather than white bread. A trapper from the northern Wisconsin woods had a very limited psoriatic eruption on each elbow. When questioned, he allowed, "It's nothing but 'silver scale'. When I get home, I'll cure it with skunk oil." He then related the preparation of this product. The scent glands were removed. Then the fat of the skunk is rendered by roasting the animal slowly in the oven. Through the courtesy of Dr. Frank L. Kozelka the physical constants of skunk oil and neatsfoot oil are appended:

	Refractive Index	Specific Gravity	Saponification Number
Skunk oil	1.4698	.9224	269.0
Neatsfoot oil	1.4745	.9030	201.7

The trapper claimed that skunk oil had the property of deep penetration. In addition to its usefulness in cutaneous disorders he claimed that it was helpful in 'deep' coughs, croup and arthritis. Speaking of the primitive life in Oklahoma, the Graven sisters said, "When we caught cold, she (mother) rubbed our chests with skunk grease and poured hot onion tea down us."

A farmer with obstinate urticaria related the following experience: "After repeated recurrences of my skin condition, I noticed that the hides of my hogs with roughening cleared when I gave them the vitriol. So I put a teaspoonful in 4 gallons of water; and whenever I needed a drink in the barn, I used the blue vitriol. I tell you, Doc, in a week I was a different man. Whenever it comes back, I use the blue vitriol drink."

From A. W. Sidie, R2, Viroqua, Wisconsin, his grandfather's cancer cure was obtained:

"1 ounce sarsaparilla
1 ounce sassafras
1 ounce bloodroot
1 ounce Epsom salt
1 ounce soda
½ ounce acetic acid (the kind found in white vinegar)."

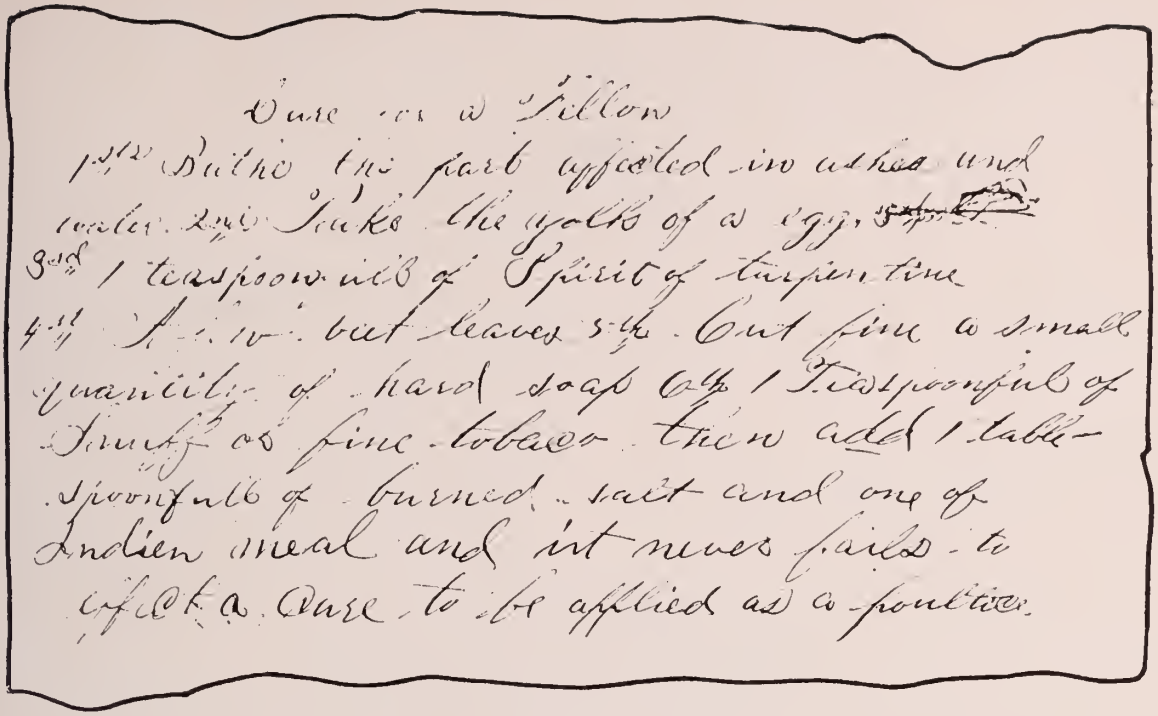
"Take 1 teaspoonful three times a day." Mr. Sidie continued, "Grandad said this should be given to the patient before anything else was done with the cancer.

"I guess it is to drive the cancer germs out of the blood. Then paint the cancer on the outside with same kind of acid and cover it with poltice (sic) of Slipping Elem (sic) bark.

"This cured a neighbor lady about 45 years ago when her stomach was in bad shape and could not eat. I saw in a paper the Dr. of England sayed (sic) the cancer was a filthy collection of the blood."

A white veteran, 72 years old, presented with impending gangrene of the great toe. The background was maturity onset diabetes with atherosclerosis. He left the hospital against medical advice and, when seen several months later, healing with a minimal sacrifice of the soft tissue of the toe had eventuated. He explained the course thus: "My wife and I collected Indian turnip (Jack-in-the-Pulpit), peeled the outer coat, cut it up and boiled it for ten minutes. We rubbed the lotion on the foot and normal healing followed."

Prompt relief of neuralgic pain has been reported



Dare or a Pillow
1st Bathe the part affected in ashes and water. 2nd Take the yolk of a egg,
3rd 1 teaspoonfull of Spirit of turpentine
4th Fry but leave s.k. Cut fine a small quantity of hard soap 6th 1 Teaspoonfull of Snuff or fine tobacco then add 1 table-spoonfull of burned salt and one of Indian meal and it never fails to effect a Dare to be applied as a poultice.

Figure 1 – A characteristic recipe for a poultice.

upon inhaling the smoke from coffee beans burned in the common pipe. Certain lay procedures are bizarre in the extreme. A woman with toxic adenoma of the thyroid gland stated that she had withdrawn the poison from the goiter by tying a live garter snake about her neck. The snake had succumbed to the procedure; but not until, in her opinion, the goiter had reduced by half in size. She added, "If we could have found another garter snake, I would not have come to the hospital." An occasional experience finds unanticipated virtue in the use of a commonplace expedient to meet a specific indication. Thus sauerkraut has proved to be most helpful in certain patients with intractable nausea and vomiting where there were no contraindications to high sodium (NaCl) intake – and a natural liking for kraut.

Therapeutic fadism is notorious among physicians. Poultices and plasters of an earlier generation have largely passed into the limbo. Denver mud and antiphlogistine are forgotten by the vast majority of physicians and co-professionals of the health team. I am willing to forget the cow manure, flaxseed and onion poultices and a number of like appliances; but certain other measures as hot stupes (with or without oil of turpentine), packs and mustard plasters have in my judgment been discarded without justification. Indeed, their withdrawal from the therapeutic armamentarium has left a hiatus which nothing fills. Perhaps my generation is sensitive on this point; but the mustard plaster is comforting to the patient with pleuritic pain and its action is not only counter-irritative, but there is a general reaction. Thewlis and W.S.M. have found a polymorphonuclear leucocyte rise in the circulating blood incidental to the local reaction. For the record, the preparation and application of the mustard plaster should follow these rules:

(a) Mix 1 part of mustard flour with 2 to 4 parts of white flour (depending on the sensitivity of the skin).
(b) Add gradually lukewarm water and the white of 1 egg to make a thick paste.
(c) Spread the mixture on muslin or cotton folding in the margins to contain the same.
(d) Anoint the affected area with a bland oil.
(e) Apply the plaster and hold in place with a towel or binder about the chest.
(f) Upon subjective sensation of burning inspect for rubor.
(g) Usually 15 to 30 minutes are required to get a proper reaction (redness).
(h) When attained, remove the plaster, gently wash the area of application with soap and warm water to remove the irritant.
(i) Dry and anoint with a bland oil: Some prefer a powder. This plaster may be reapplied one or two times in 24 hours and is most comforting to the patient.

Many other procedures have suffered the same fate. In Osler's first edition (1892) there is mention of the occasional disappearance of a pericardial effusion subsequent to the application of emplastrum cantharides to the precordium. The modern generation discarded Spanish fly when its reputed action as an aphrodisiac proved unfounded. So progress takes its toll; but it may be well to pause in our headlong flight from time to time in order to weigh the cost of advance. ■

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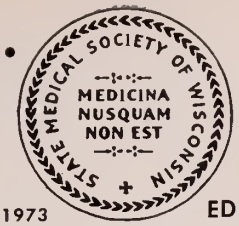

OPHTHALMOLOGY

FEBRUARY 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

VISUALLY HANDICAPPED CHILDREN

The State of Wisconsin has an obligation to educationally serve the visually impaired children within its borders, not only those who are totally blind but also those with vision of 20/70 or less in the better eye. As the Supervisor for the Visually Handicapped, I would like to prevail upon ophtalmologists to assist our office in finding all children with visual impairments. Presently, only a few ophthalmologists direct referrals to the Division for Handicapped Children. We would like to know of all children in order to assist and advise parents of all services available for visually impaired youngsters.

Are you aware that the State of Wisconsin has school programs for the visually impaired? They are part of the public schools, located within various regions of the state. The programs serve children who are eligible and can benefit from this special placement. Within these programs the visually impaired are mainstreamed into the regular grades and are assisted by a trained teacher in the area of the visually impaired. Materials are provided such as large print books, braillers, and special equipment for the visually impaired. These programs serve the totally blind and partially sighted.

Are you aware that the Wisconsin School for the Visually Handicapped in Janesville serves all degrees of blindness, not just the totally blind? The facility is a residential school where children can receive a high school diploma and participate in all the usual high school activities in order to develop into independent adults. They are served through the assistance of a highly trained staff dedicated to serve the visually impaired.

Are you aware that each year a Preschool Conference for parents of visually impaired children is held at the Wisconsin School for the Visually Handicapped in Janesville? This conference gives parents an opportunity to meet one another and hear speakers who assist them in better understanding their visually impaired child. Last year the speakers included Dr. Thomas D. France, University Hospitals, Madison; Dr. Richard Umsted, Ohio State University; and Vernon Jaeschke, a certified physical therapist, Edgerton. The staff at the Wisconsin School for the Visually Handicapped participated by sharing techniques of teaching, discussing what can be expected of preschool children, and presenting their limitations.

Confidentiality is strictly adhered to and ophthalmologists' assistance would be greatly appreciated. As Consultant and Supervisor for the Visually Impaired, our goal, as yours, is to serve children with visual problems.

A letter from the person making the referral begins the process of eligibility and available service. Substantiation of need and eligibility for educational placement is based upon completion of the ophthalmological report form.

Referral letters and ophthalmological reports can be sent to: Mr. Andrew Papineau, Supervisor for the Visually Handicapped, Division for Handicapped Children, 126 Langdon Street, Madison, Wis. 53702; phone: 608/266–3338.

NEW OPHTHALMOLOGIST IN THIENSVILLE

Arthur F. Garcia, MD, of Cedarburg recently opened an office for the practice of ophthalmology in Thiensville. He received his MD degree from the University of Illinois in 1966. From 1966–1967 Doctor Garcia interned at Milwaukee County General Hospital. His ophthalmology residency was in the former Marquette Teaching Hospitals program (now the Medical College of Wisconsin) from 1967–1970. Doctor Garcia recently completed two years of military service in the U.S. Public Health Service at the National Eye Institute, NIH, Bethesda, Md.

HELP NEEDED WITH EYE EQUIPMENT

The Health Service Corps physician in Menominee County, Michael Reinardy, MD, is badly in need of ophthalmological equipment, particularly a Schiotz tonometer, retinoscope, and loupe as well as other medical equipment. Any physician or physician's widow who might be in a position to help Doctor Reinardy and the Menominee residents may do so through (tax-deductible) donations to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. Inquiries may be made to: Terrance S. Goerne, CES Foundation, Box 1109, Madison, Wis. 53701; or by phoning 608/257–6781, ext. 289.

DATES TO REMEMBER

Feb. 27: Milwaukee Ophthalmological Society. Richard O. Schultz, MD, Milwaukee, "A Review of Diagnostic Problems in External Disease;" and Robert A. Hyndiuk, MD, "Recent Innovations in the Treatment of Corneal and External Disease."

Mar 27: Milwaukee Ophthalmological Society (and State Medical Society meeting). Charles Iliff, MD, Baltimore, "Dacryocystorhinostomy and the Surgical Management of Mucoceles Present in the Orbit" and "Surgical Approach to Ptosis." □

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WISCONSIN MEDICAL JOURNAL
Vol. 72, No. 2 FEBRUARY 1973

Medical
STATE MEDICAL SOCIETY OF WISCONSIN
GREEN SHEET

ANNUAL MEETING

Society's House to Consider Future of WPS

The future of WPS, the State Medical Society's Blue Shield plan, hinges on a decision to be made by the House of Delegates at its annual meeting in Milwaukee March 25–27.

At issue is whether the State Medical Society should continue, as it has for 27 years, to guide the policy direction of WPS.

Pushing the Society toward the critical decision is the Legislature's revision of Wisconsin's insurance laws. The first stage of the revision, affecting all insurance organizations other than the nonprofit plans, was enacted into law in 1972. It now is known as Chapter 611 of the Statutes.

Next in line for revision are the laws affecting all nonprofit health service plans such as WPS–Blue Shield, Surgical Care–Blue Shield, and Blue Cross. The revision project is directed by Spencer Kimball, former dean of the UW law school.

Thirty-five of the resolutions to be presented to the House of Delegates in March appear in summary form on page 35.

He proposes that present enabling laws for these plans be scrapped in favor of a totally new law (Chapter 613) which would require WPS and Surgical Care to incorporate separately from their parent organizations, the State and County medical societies. Separate incorporation is felt desirable by Dean Kimball and others in the interests of uniformity and to assure that the assets of the Blue Shield plan cannot be used to the advantage of the medical society or its members.

Although the Kimball proposal isn't yet in the legislative hopper, its introduction is expected soon. In the past his proposals have won approval from the state's lawmakers.

Thus the Society's House of Delegates faces a decision not on whether to separately incorporate, but how. The options are these:

Options for Decision

OPTION 1—Incorporate under proposed Chapter 613 as a nonprofit health service corporation. The members of the State Medical Society would be the members of this provider-oriented corporation. The Society would continue to name all the medical and consumer members of the board of directors of the new WPS plan. Thus it would have direct participation in policymaking and administration, as it has since the start of WPS in 1946. Later, if it wished, WPS could convert to either a stock or mutual corporation with the Insurance Commissioner's okay.

OPTION 2—Incorporate under present Chapter 611 as a nonprofit stock insurance company. The State Medical Society would continue as it does now to own WPS. Stock ownership would, however, be stripped of any possibility of financial gain or profit to the Society or its members. This would be done by forbidding the stock to receive any cash dividends and by providing that if the corporation were ever dissolved assets remaining after

An Invitation

All members of the Society are invited to come to meetings of reference committees of the House of Delegates at the 1973 Annual Meeting in March. Four committees will hear discussions of proposals for House action submitted by county medical societies and scientific sections of the State Medical Society.

Committee meetings will start at 7:00 pm Sunday, March 25, in Milwaukee's Pfister Hotel. Reference committees and their locations are:

RESOLUTIONS–AMENDMENTS
Imperial Ballroom

OFFICERS
Taft Room

STANDING COMMITTEES
McKinley Room

FINANCE
Richard II Room

Also at that time, the Planning Committee will hold an open hearing in the Roosevelt and Kennedy Rooms. This committee has proposed a number of changes in the State Medical Society's Constitution and Bylaws. It is particularly interested in learning of any needed changes in committee structure or duties. It will continue its open hearing on Monday, March 26, from 2 to 4 pm in the Empire Room.

paying all liabilities would go to the University of Wisconsin Medical School. The Society would continue to name all members of the board of directors, both medical and consumers. Later, if the Society wished, it is believed that WPS could convert to a mutual, but not to a Chapter 613 corporation.

OPTION 3—Incorporate as a nonprofit mutual insurance company under present Chapter 611. In taking this step, the medical profession would give up both legal control of WPS and numerical control of its board of directors.

The Commission on Medical Care Plans has recommended the mutual approach with a 15-man board of directors, 8 of whom would be nonmedical. It is believed that such a plan could not later convert to a Chapter 613 plan, and probably would encounter difficulty in becoming a stock company.

WPS As a Stock Company?

Option 2 or 3 could be accomplished now if the Insurance Commissioner approved. Option 1 is available only after Chapter 613 becomes law. In any event, the House of Delegates has been asked to give its approval before the Society exercises any of the three options.

The Council of the State Medical Society, meeting on February 10, asked that the House of Delegates give first preference to reorganization of WPS as a stock company (option 2). If that is not possible, the mutual (option 3) is to be considered, but not before the entire matter is returned to the Council for further discussion.

Debate is apt to be keen. At stake is the amount of direct contribution the SMS can make to the delivery and financing of health care through a Blue Shield plan under its policy and administrative supervision. Some doctors say it's time the Society got out of the insurance business. Other doctors fear that the pace-setting innovations of WPS in previous years (broad benefits, full payment of doctors' charges, health maintenance plan, etc.) would flounder for lack of doctor support without direct medical society contribution. In any event, they say, the loyalty of doctors to WPS would dwindle if the plan was "just another mutual insurance company."

Delegate discussion won't overlook the fact that the Medical Society of Milwaukee County is faced with the same decision as to how and when to separately incorporate its Blue Shield plan known as Surgical Care. At this stage no one is quite sure what impact the decision of one society might have on the Blue Shield plan of the other. Nor is anyone predicting the effect of separate incorporation on current talk of merging the two Blue Shield plans into a new and separate Blue Shield corporation serving the entire state.

The pros and cons of each option are many. There are some advantages to waiting for the passage of Chapter 613. It probably brings about separate incorporation with the least disruption or change in the present direction and operations of WPS. Policy direction is retained by SMS, although consumers are permitted on the board of directors. But there are potential disadvantages too. Chapter 613 would be a new, untested law applying only to a handful of companies.

WPS As a Mutual Company?

To avoid such an uncertain climate, some propose the stock or mutual route. Greater safety, they say, lies in the fact that more than 1500 companies already do business this way. This would give WPS more allies in event of special or inconsistent regulation.

With the nonprofit stock option, the Society clearly retains policy direction while the nonprofit mutual route turns ownership over to the policyholders. Insurance experts, however, point out that policyholder control is more theoretical than actual. In a typical mutual, control is vested in the board of directors and management. They contend that this would cause a mutual health plan to be more rigidly supervised by the state than either a stock company or a Chapter 613 corporation. Proponents counter with the view that the time of the consumer has come; that physician control of Blue Shield plans is a "conflict of interest," and that reorganization of WPS to grant ownership and majority voting rights to WPS policyholders will "reflect public credit upon the State Medical Society."

The 143 members of the House of Delegates, elected from the 54 county medical societies and 18 scientific sections, face no easy decision. Their vote in March may well determine whether the SMS continues to be a direct and moving force in health care financing in Wisconsin, or whether it drops out, leaving the field to others.

WPS Started in 1946

The SMS created its WPS division in 1946 under a legislative charter which permits state and county societies to organize "sickness care plans." The Society's Commission on Medical Care Plans serves as the board of directors for WPS under delegated authority from the House of Delegates and the Council. Currently the Commission has 21 physician and 3 non-medical members.

It has an enrollment of about 500,000 persons, paid out $44.4 million dollars in benefits in 1972; has assets of $31.2 million dollars and uncommitted reserves of about $10 million dollars. WPS also acts in a carrier role for the administration of Medicare. Last year it paid out $27,-114,384 in Medicare benefits. It serves in a similar role for the state in administration of Medicaid, paying out $25,987,000 in benefits in 1972. Hopefully, the new corporation which is the successor to WPS would continue to qualify as administrator of these important government contracts. This is not a foregone conclusion, however. □

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Resolutions from WISPAC to Safety

The following resolutions were received in the Secretary's office by January 25. These will go to the State Medical Society's House of Delegates for action at the Annual Meeting March 25–27 in Milwaukee. Members are urged to express their opinions to their delegates and to participate in the Reference Committee sessions where resolutions are discussed in detail (see box for time and place).

(The county medical society or scientific section that has introduced the resolution appears in parentheses.)

A. *(Fond du Lac)* **WISPAC.** Asks "that WISPAC inform its members of swing areas in the state and the philosophy of those candidates towards health care." It further resolves "that all funds channeled through WISPAC must be designated by the donor for a specific candidate and that WISPAC as an organization not have the authority to contribute unmarked funds."

B. *(Fond du Lac)* **AMPAC.** Asks "that AMPAC inform its members of swing areas in the country and the philosophy of those candidates towards health care." It further resolves "that all funds channeled through AMPAC must be designated by the donor for a specific candidate and that AMPAC as an organization not have the authority to contribute unmarked funds."

C. *(Waupaca)* **Medic-Alert Information.** Asks "that the State Medical Society of Wisconsin request the State Department of Transportation, Motor Vehicle Division, to allow the person to list his medical alert information on the back side of the driver's license. That is: Disease—heart disease, diabetes; Allergies —to drugs, medication; Drugs used—(example) Coumadin, etc."

D. *(Waupaca)* **Professional Liability.** Asks "that the State Medical Society of Wisconsin sponsor and support legislation requiring a Plaintiff seeking punitive damages in a malpractice suit to post a $2,500 bond; such bond could be used for the defendant for legal costs if no punitive damage was granted or, if the suit is dropped, by the claimant. (This law could be similar to Senate Bill #941, Chapter 653 of the State of California.)

E. *(Dane)* **Membership.** Asks "that the bylaws and constitution of the State Medical Society of Wisconsin be changed to permit a fully accredited physician to become a member of his county medical society and the State Medical Society of Wisconsin without simultaneous membership in the American Medical Association."

F. *(La Crosse)* **Election of Officers and AMA Delegates.** Asks "that the nominating committee be constituted of one member from each district elected by the district delegates at the time of the annual meeting;" and "that this committee remain active throughout the year during which time individual members of the Society can submit the names and credentials of potential candidates to the nominating committee;" and "that the nominating committee convene two months prior to the annual meeting of the State Medical Society in order to prepare a slate of candidates; this meeting, to be held at the State Medical Society headquarters, shall include an open session for purposes of personal nomination of candidates." It further asks "that the slate of candidates obtained at this time be published in the Journal of the State Medical Society at least one month before the annual meeting with a brief biographical sketch of each candidate" and "that the current practice of open nomination from the floor of the House of Delegates be continued."

G. *(La Crosse)* **Member Participation in AMA Policy Decisions.** Asks "that the AMA delegation and their alternates hold an open hearing at the time of the annual meeting of the State Medical Society of Wisconsin for purposes of obtaining information and opinions from individual members of the state society" and "that the timing of the annual meeting of the State Medical Society of Wisconsin be coordinated with the national meeting to allow for implementation of this resolution."

H. *(Anesthesia)* **Accreditation Program for Continuing Medical Education.** Asks "that the State Medical Society of Wisconsin establish a Committee on Continuing Medical Education, or some other group, to establish an accreditation program in medical education for Wisconsin under the auspices of the American Medical Association; provided that the establishment of such a state organization should be accomplished as soon as possible and should, in general, be prepared to survey and accredit those continuing medical educational programs submitted to it by intra-state organizations and hospitals."

I. *(Dane)* **Election of Officers.** Asks "that election of officers, including the President, President-Elect, Treasurer, Speaker and Vice-Speaker of the House of Delegates, shall be accomplished by a mail ballot of the membership of the Society" and "that the Planning Committee of the Council be asked to study the details of this method of electing the officers enumerated above and that it submit to the 1974 House of Delegates appropriate language necessary to implement this resolution and change the Bylaws.

J. *(Dane)* **Peer Review Committees.** Asks "that with the passage of PSRO provisions of HR-1, it is strongly urged that county medical societies, or groups of county medical societies on a geographic basis, formulate peer review committees which are affiliated with Wisconsin Health Care Review, Inc. The structure and function of such committees should be organized in accordance with PSRO regulations and directed by the providers of medical services."

K. *(Dane)* **Residents, Interns, Medical Students.** States "that the renewed interest of resident physicians in the affairs of organized medicine mandates that the House of Delegates establish a new section to enable residents a voice and vote in the affairs of the Society." Asks "that the House of Delegates establish an advisory section for interns and medical students."

L. *(Dane)* **Medical School Family Practice Programs.** Asks "that commendation be extended to the continuing efforts of the University of Wisconsin Medical School and the Medical College of Wisconsin in establishing and promoting family practice."

M. *(Milwaukee)* **Current Procedural Terminology (CPT).** Asks "that the State Medical Society of Wisconsin:

"1. Direct WPS and Surgical Care to accept claims for services coded by this system and to indicate to private carriers that this is the only coding system sanctioned by the State Medical Society of Wisconsin.

"2. Encourage all physicians to use CPT in describing their services and actively promote this among state physicians."

N. *(Milwaukee)* **Protection and Preservation of Human Life.** Asks "that the State Medical Society of Wisconsin reaffirm its dedication to the protection and preservation of human life and condemn euthanasia in any of its forms, abortion under any guise, except for valid medical indications, and finally the wanton removal or destruction of normal body structures and organs unless the medical need of the whole body so dictates."

O. *(Langlade)* **Abortion on Demand.** Asks "that the House of Delegates of the State Medical Society of Wisconsin go on record as being against abortion on demand in favor of the life of the unborn."

P. *(Langlade)* **Uniform Schedule of Fees for All Physician Members.** Asks "that the House of Delegates of the State Medical Society of Wisconsin support the concept of equal fee for equal service, thereby a uniform schedule of fees for all physician members."

Q. *(Fond du Lac)* **AMA Delegates' Terms.** Resolves "that delegates shall be eligible for election for no more than three (3) consecutive two-year terms."

R. *(Fond du Lac)* **Use of Standards Forms in Practice of Obstetrics and Pediatrics.** Asks "that standard forms be approved by the Wisconsin Society of OB–GYN, Wisconsin Chapter of the American Academy of Pediatrics, State Division (sic) of Health and Social Services, State Academy of Family Physicians, and the Wisconsin Association for Perinatal Care, and be used by all physicians engaged in the practice of obstetrics and pediatrics in the State of Wisconsin."

S. *(Juneau)* **Realistic Support of Rural Health.** Asks "that the House of Delegates of the State Medical Society of Wisconsin realistically support rural health and seek to improve the distribution of medical services to the public as follows:

"1. Eliminate the inequality in reimbursement for services of rural physicians for the reasons given in the AMA House of Delegates Resolution.

"2. Recognize that 'COMMUNITY' wherein physicians practice is the entire COMMUNITY of physicians practicing in Wisconsin; and apply this concept in establishing customary, usual and reasonable fees.

"3. ACT forthwith to gain approval of PHASE III to realize these goals for rural health."

T. *(Marathon)* **Public Health Legislation.** Asks "that the State Medical Society of Wisconsin seek action in the Wisconsin legislature to enact the following into law:

"1. That all persons be evaluated by a physician and a certified audiologist prior to the purchase of a hearing aid.

"2. Be it further resolved that the State Medical Society of Wisconsin supports the Wisconsin Speech and Hearing Association in their attempt to provide licensure for speech pathologists and audiologists."

U. *(Rock)* **Employment of Physicians by Hospitals.** States that "existing Wisconsin law now prohibits employment of physicians on a salaried basis by hospitals." Asks "that the State Medical Society of Wisconsin oppose the repeal of this existing Wisconsin Law, as previously recommended by the Governor's Health Planning and Policy Task Force."

V. *(Marinette)* **Medical Student Experience in Health Manpower Shortage Areas.** Asks "that the Medical College of Wisconsin and the University of Wisconsin Medical School provide opportunities for medical students in health manpower shortage areas by offering a program designed to have students work for a minimum of one month in a health manpower shortage area before graduation." It also asks "that this program involve supervision of students by medical school faculty on site in the manpower shortage area" and "that such a course be a requirement for graduation from both of the state's medical schools."

W. *(Green Lake–Waushara)* **Unionization of Medical Practitioners.** Asks "that the Council and the Secretary of the State Medical Society of Wisconsin do

"1. take a statewide poll of all physician members of the State Medical Society to determine whether the majority of the members are interested in unionization, and

"2. in the event that the majority of the members vote for unionization, such organization efforts be carried on with all the dispatch through the State Medical Society in cooperation with other state societies carrying on this same work with the ultimate goal being the amalgamation of all fifty state societies' union activities onto one large national union."

X. *(Green Lake–Waushara)* **"The Case for American Medicine."** Asks "that the State Medical Society of Wisconsin immediately purchase enough copies of the aforementioned book so that one copy may be sent to each member of our congressional delegation in Washington and to any other interested officer of our Government with a note indicating our interest in their work in the health care field and with the hope that they will take the time to read this book."

Y. *(Green Lake–Waushara)* **Licensure Re-Examination.** States that "legislation will soon be considered by Congress making it mandatory that physicians will have to undergo periodic medical license to practice." Asks "that the State Medical Society of Wisconsin take a stand against such legislation until such time as all professional people, i.e. attorneys, dentists, nurses, etc., are required to undergo the same type of re-examination."

Z. *(Green Lake–Waushara)* **Statewide Minimum and Advisory Fee Schedule.** Asks "that the State Medical Society of Wisconsin take immediate action to implement the evolvement of a statewide minimum and advisory fee schedule such as has been done in other states to serve as a guideline only for the physician."

AA. *(Green Lake–Waushara)* **Title XIX Claims Handling.** Asks "that the State Medical Society of Wisconsin House of Delegates indicate that an immediate change in the reporting of Medicaid payments must be considered in order and that the House of Delegates demands that the Title XIX Program follow procedures found acceptable with all other insurance programs and, therefore, should return to the vendor one copy of his claim submitted for payment with indication on this copy as to what services or supplies were paid for and what services or supplies were not paid for, the reason for nonpayment, and the amounts of money paid. The listing of bills paid along with the amounts does not afford the physician's secretary an opportunity to balance her books and in addition, it is not accepted bookkeeping procedure. In view of the fact that the physicians have been waiting seven years now for such a change, it would appear that this change is long past due and in order."

BB. *(Green Lake–Waushara)* **Medicredit.** States that "on January 18, 1973, a new Medicredit Insurance Bill was introduced to Congress for action." Resolves "that the State Medical Society of Wisconsin fully supports this particular legislation by contacting our congressional delegation and with newspaper ads and stories and by whatever other means would make our position as physicians known to the public."

CC. *(Door–Kewaunee)* **Removal of Eyes Donated for Transplant Surgery by Licensed Morticians.** Asks "that the State Medical Society of Wisconsin promote state legislation allowing the removal of eyes from deceased eye donors by licensed morticians for the purpose of transplant surgery."

DD. *(Waupaca)* **Quality Assurance Program.** Asks "that the State Medical Society of Wisconsin reject any proposed 'Quality Assurance Program' such as that recently announced by the American Hospital Association."

EE. *(Douglas)* **National Health Service.** Asks "that the State Medical Society of Wisconsin express its grave concern regarding the trend to total National Health Service with the advent of H.R. 1 and the Professional Standards Review Organization" and "that the State Medical Society of Wisconsin make known to our national leaders this concern."

FF. *(Douglas)* **Governor's Health Policy and Planning Task Force Report.** Asks "that the State Medical Society of Wisconsin endorse the Minority Report on a Health Services Commission in Governor Lucey's Task Force Report" and "that a further request for consideration of this report be submitted to the Governor."

GG. *(Douglas)* **Preservation of Wisconsin's Natural Habitat.** Asks "that the State Medical Society of Wisconsin through its Committee on Ecology (Commission on Health and Natural Resources) extend our fullest cooperation to the Wisconsin Department of Natural Resources in the further preservation of Wisconsin's natural habitat."

HH. *(Douglas)* **Medical Student Summer Externship Program.** Asks "that the State Medical Society of Wisconsin extend its thanks in appreciation to the University of Wisconsin Medical School and the Medical College of Wisconsin for their cooperative efforts in their Summer Externship Program."

II. *(Douglas)* **Safe Transportation.** Asks "that the State Medical Society of Wisconsin request the American Medical Association to restore and reactivate its Committee on Medical Aspects of Automotive Safety." □

ANNUAL MEETING

Sign of the Times

A sign of the times, Monday, March 26, the State Medical Society's Annual Meeting will feature two authorities on medicine's increasing involvement in the political process.

Socio-economic Luncheon. James R. Kimmey, MD, newest arrival on Wisconsin's health care regulatory scene, will speak at 12:15 pm in the Pfister Hotel's Imperial Ballroom. Dr. Kimmey started work this month as part of Gov. Patrick J. Lucey's administration (see last month's GREEN SHEET). He is the governor's special assistant for health policy and executive director of the state Health Policy and Program Council.

The Council is a new state agency established by executive order in May 1971 to coordinate a number of state activities in the health area. When Governor Lucey leaves office, the Council's executive order will end. Therefore, legislation is currently being sought that would make the Council a permanent body.

Dr. Kimmey is a veteran of the U.S. Public Health Service, a New York health planning group, and the American Public Health Association (APHA). He was APHA's executive director from June 1970 until returning to Wisconsin last month. In his new job his most important task will be to pick up where the Governor's Health Task Force left off and implement many of its recommendations. Working alongside him will be Ben Lawton, MD, Marshfield, who is chairman of the Council.

Dr. Kimmey is a Wisconsin native and received BS, MS, and MD degrees from the University of Wisconsin–Madison. He also holds a Master's of Public Health from the University of California, Berkeley.

Public Affairs Dinner. Rose and Hoyt Gardner are models of medicine's involvement in the democratic process. He is a Louisville surgeon and chairman of the American Medical Political Action Committee (AMPAC). She is vice-chairman of the Kentucky KEMPAC Board of Directors and legislative chairman

HOYT and ROSE GARDNER
Involved in democratic process

of the Woman's Auxiliary to the American Medical Association.

Their joint appearance (at 7:30 pm in the Pfister Hotel's Imperial Ballroom) is especially fitting, since the Society's cosponsor for the dinner is its Woman's Auxiliary.

Dr. Gardner has been AMPAC chairman for two years, a position which has taken him around the country to state, regional, and national PAC meetings and workshops. He also is a member of the Electoral College from the State of Kentucky.

He works hard to keep state PACs involved and enthusiastic. In a column in last November's AMPAC newsletter, *Political Stethoscope,* he was justifiably proud to note that "we have more friends on both sides of the aisle in this the 93rd Congress than we have ever had."

His busy schedule is intensified by his membership on the Board of Trustees of the University of Louisville Medical School and his activities in the Kentucky State Medical Association.

Mrs. Gardner is equally involved. Over the past ten years the mother of three sons has held a dozen positions in the county, state, and national woman's auxiliaries. She also has attended meetings on behalf of the Kentucky State Medical Association, is active in state political organizations and governor's committees, and is treasurer of the local high school booster club.

She became national chairman of the AMA Auxiliary's legislative committee last June. She previously had served two terms as the national auxiliary's southern regional legislative chairman.

Other current posts include membership on the Health Manpower Committee for the Kentucky State Medical Association,

DR. KIMMEY
Implementation job ahead

coordinator for the Woman's Auxiliary to the Kentucky Medical Association, auxiliary member at large of KEMPAC and vice-chairman of its board of directors.

The public affairs dinner is at 7:30 pm Monday, March 26, in the Pfister Hotel's Imperial Ballroom. Reservations are $12/person and should be made with the State Medical Society. □

ANNUAL MEETING

Sopra Mare

Medical antiques in an Italian villa on the Milwaukee shores of Lake Michigan. This unusual treat is being planned for the first day of the State Medical Society's Annual Meeting in Milwaukee next month.

The Woman's Auxiliary and the CES Foundation will host a medical antique show from 4 to 8 pm at Villa Terrace, a splendid Italian villa high on a bluff overlooking Lake Michigan. Anyone having antiques of medical interest is invited to bring them to the display, which will also feature the Villa Terrace's antique furniture dating from the Renaissance to as late as 1900.

The Villa was built in the early 1920s for Mrs. John J. Curtis and her husband, the late L. R. Smith, son of the founder of the A. O. Smith Corporation. With its donation to the community by Mrs. Curtis, it is now a Branch Museum for the Decorative Arts of the Milwaukee Art Center.

The house is in the 16th Century architectural style. It was designed by Milwaukee-born David Adler, considered the last of the great revival architects. One of its major features is the terraces which cascade down the lake bluff to a formal garden on the beach level below. Mrs. Curtis originally named the villa Sopra Mare (above the sea) and the name was changed when it became a Museum.

Those who would like to exhibit medical antiques for the show should contact Mrs. Kenneth Smigielski, 3351 W. Poe St., Milwaukee, by March 15. They must be delivered to the Villa Terrace (2220 N. Terrace Ave.) by 1:30 pm on March 25, where there will be security guards. There will be a $2 charge to view the exhibit.

The CES Foundation and the Auxiliary will also team up on Tuesday morning, March 27, during a continental breakfast at 8:30 am in the Holiday Inn's Garden Terrace Room. Terrance Goerne of the Foundation will speak on ways the newly formed Aesculapian Society (Museum Guild) can help promote the Foundation's Museum of Medical Progress in Prairie du Chien.

The Aesculapian Society was formed late last year by members of the Auxiliary to help the Museum establish new exhibits. All members of the Auxiliary are invited to the breakfast. □

STAT

The seemingly endless cliffhanger over construction for Wisconsin's two medical schools went into another installment this month. Former Health Task Force master **David Carley** was asked by Governor Lucey to study relationships between the state and the Medical College of Wisconsin (MCW). MCW was left in the cold by the federal government last fall when its request for funds to build a new basic science building was denied. Currently under scrutiny is its request for a state operating subsidy of $4.4 million. There has been speculation that Mr. Carley's report may affect the future of both medical schools. The University of Wisconsin has a request pending for funds to build the second part of its Medical Center.

■

With an eye toward the stunningly anti-chiropractic report produced by Governor Lucey's Health Task Force last fall, the American Medical Association has asked the State Medical Society to host its **Midwest Conference on Quackery.** Four or five hours of workshop sessions on quackery, chiropractic, and related subjects will be held in Madison on Saturday, April 14. A highlight of the meeting will be a luncheon with a well-known speaker, probably dealing in a major way with chiropractic. The luncheon is open to the general public and the press. The rest of the session will be a unique opportunity for physicians and staff members of the medical societies of Ohio, Indiana, Michigan, Illinois, Wisconsin, Minnesota, and Iowa to get some first-hand information.

■

Some "sacred cows" in the health arena, such as the Hill–Burton hospital construction program and Regional Medical Programs, get the ax in the Nixon Administration's 1974 budget. These would be the unkindest cuts of all, according to a statement by the President of the Medical Society of Milwaukee County, **Jules D. Levin, MD.** Dr. Levin said the result would be "a bleak future" for the American health care system. He said eliminating such funding "seems to represent a departure from what the public is demanding in the way of improvements of our nation's health care system."

■

The controversial PSRO (Professional Standards Review Organization) has engendered at least two new committees for medical societies. Wisconsin is well represented on both of them. **William B. Hildebrand, MD,** Menasha, chairman of the AMA Council on Medical Service is one of 23 members of the AMA's Advisory Committee on Professional Standards Review. This was formed to assist state and county medical societies by making recommendations on the development of PSROs and their organizational structure. An ad hoc committee of the American Association of Medical Society Executives has been formed to plan informational workshops on PSROs across the country. Among the 10 members are **Earl Thayer,** secretary of the State Medical Society of Wisconsin, and **Michael McManus,** executive director of the Medical Society of Milwaukee County.

■

NBC is really sorry that the nation's physicians are displeased with the TV program **"What Price Health?",** but sympathy is one thing and equal time is another. That, in effect, is what NBC Vice President Donald Meaney told Society President Robert F. Purtell, MD, in a letter last month. In his letter, Mr. Meaney carefully reviewed NBC's past news and feature coverage of the health care scene. He said the coverage has been good enough that NBC's executives "do not believe that an opportunity to reply to 'What Price Health?' is required." Meanwhile, AMA executive vice president Ernest B. Howard, MD, sent NBC a blistering 12-page point by point protest of the program. He said equal time was required because the program "was nothing more or less than a pitch for the Kennedy–Griffiths health insurance proposal." And, over at CBS, M. Stanton Evans devoted two of his "Spectrum" radio broadcasts to raking the "What Price Health" over the coals. He called it "partisan pleading in the guise of news" and said it "ranks with the all-time worst." □

MR. McINTYRE
More impetus in quality review

WHCRI

New Direction

Donald J. McIntyre, Sun Prairie, has been named executive director of Wisconsin Health Care Review, Inc. (WHCRI). He has overall responsibility for the year-old review corporation which has taken on added significance since passage of the 1972 amendments to the Social Security Act. These call for a review of the professional standards of care given Medicare and Medicaid patients.

It is expected that organizations like WHCRI will be used as a mechanism to accomplish this review. WHCRI will also be equipped to administer ongoing quality review for the insurance industry.

Mr. McIntyre has been a State Medical Society executive for the past six years. He has held a series of positions including assistant insurance director of WPS–Blue Shield, WPS director of government programs, director of the WPS experimental health maintenance programs, and legislative counsel for the State Medical Society.

WHCRI recently announced the appointment of four public members to its board of directors. They are:

- LEE S. DREYFUS, chancellor of University of Wisconsin–Stevens Point;
- HELEN E. NELSON, director of the Center for Consumer Affairs at the University of Wisconsin Extension, Milwaukee;
- JOHN G. SCHUTZ, executive vice president of Research Products Corporation, Madison; and
- Rusk County Judge RODNEY L. YOUNG, Ladysmith.

They bring the present number of WHCRI directors to 12. The other 8—four physicians, two dentists, and two hospital administrators—were named a year ago when the corporation was formed. The Wisconsin Academy of Osteopathic Physicians and Surgeons has also been invited to name a representative on the board.

To date six health-care provider organizations have appointed representatives to WHCRI's advisory panel. They are the Wisconsin Pharmaceutical Association, Wisconsin Nurses Association, Wisconsin Association of Nursing Homes, Wisconsin Optometric Association, Wisconsin State Podiatry Society, and the Wisconsin Chapter of the American Physical Therapy Association.

These six (and possibly others if the advisory panel is expanded) will develop guidelines for any review involving their disciplines.

WHCRI was formed by the State Medical Society, the Wisconsin State Dental Society, and the Wisconsin Hospital Association. Its aims are protection of the patient, furtherance of professional education, and conservation of funds, both public and private. □

ANNUAL MEETING

Constitutional Amendments

Among the important matters to be decided by the House of Delegates in March are the amendments to the Society's Constitution and Bylaws.

Two amendments to the Constitution appear on page 9 of this issue as official notification to the membership.

One involves rewording of the Society's Purpose Clause to more accurately reflect current thinking.

The other involves councilor election by the delegates in respective councilor districts with confirmation by the House.

ABORTION

Still Questions

Wisconsin's abortion law has been rendered entirely unconstitutional and unenforceable by the January 22 United States Supreme Court decision involving Texas and Georgia abortion laws, according to Atty. Gen. Robert Warren.

Mr. Warren, in a letter to all Wisconsin district attorneys, called the fashioning of a new abortion law for the state an immediate responsibility for the Legislature and the Medical Examining Board.

He said it appears from the high court opinion the state may enact laws which:

. . . prohibit abortions by anyone who is not a licensed physician;

. . . regulate abortions after the first three months of pregnancy to preserve and protect maternal health (including qualifications and licensure for both the physicians doing abortions and the facilities where the procedure is done);

. . . prohibit abortions except to save the life or health of the mother after the fetus can have "meaningful life outside the mother's womb;"

. . . regulate "any medical or surgical procedure connected with abortion."

Mr. Warren said the Supreme Court opinion did not answer the question of whether a father has the right to help make the decision on whether an abortion would be performed.

Also unanswered, he said, is whether parental consent will be required in the case of an abortion performed on a minor. Both questions will have to await further litigation, Mr. Warren said.

(Two resolutions prepared for the State Medical Society's Annual Meeting in March deal with abortion.

(One, from the Medical Society of Milwaukee County, condemns abortion and euthanasia except for valid medical reasons.

(The other, from the Langlade County Medical Society, asks that the House of Delegates come out against abortion on demand.) □

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While Valium can be a most lpful adjunct to your counseling, should be prescribed only as long excessive psychic tension per- ts and should be discontinued hen you decide it has accom- ished its therapeutic task. In neral, when dosage guidelines e followed, Valium is well lerated (see Dosage). For con- nience it is available in 2-mg, 5-mg d 10-mg tablets.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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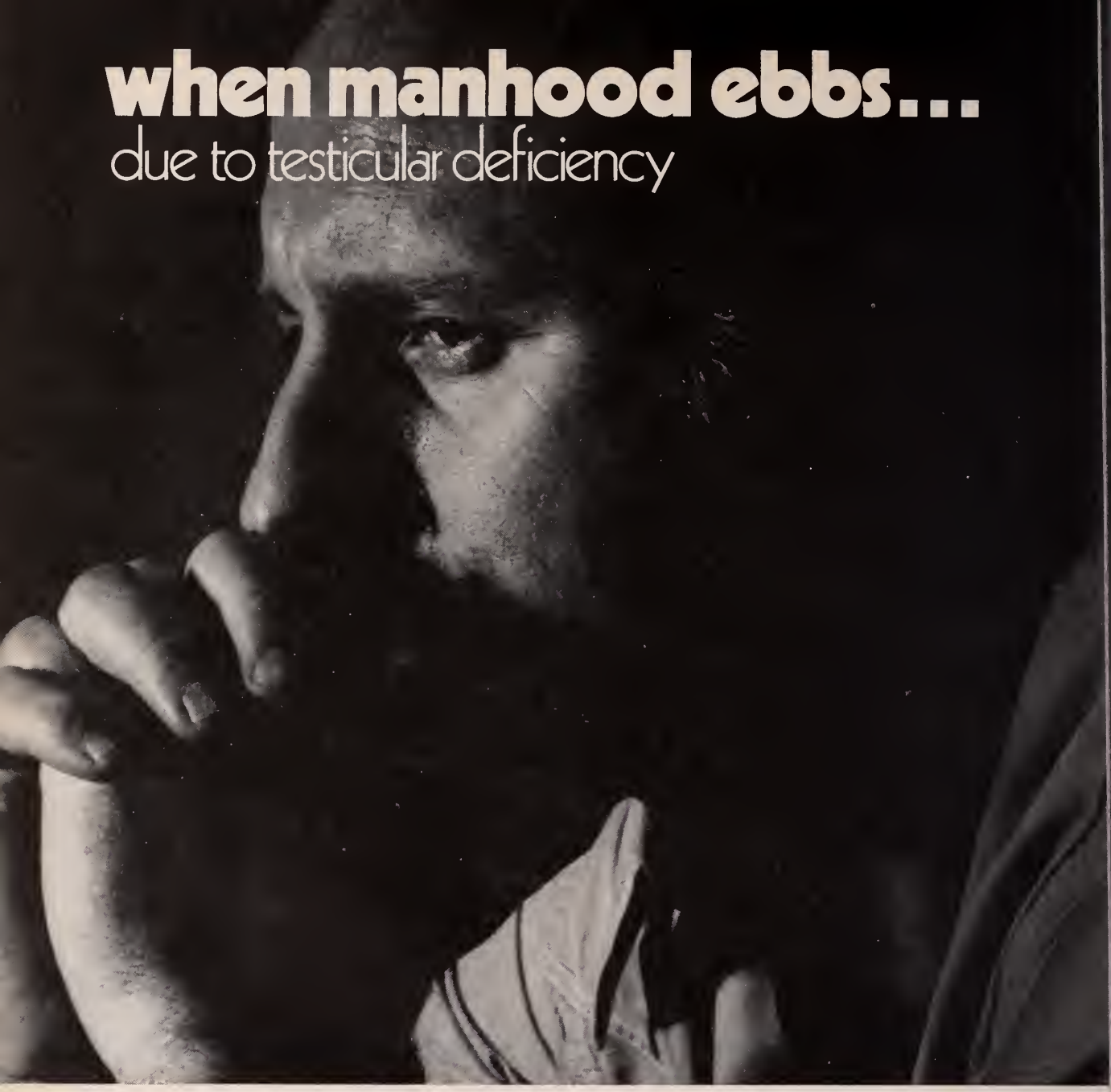

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.
Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive se stimulation, oligospermia, reduced ejacula volume, hypersensitivity and gynecomastia occur. When any of these effects appear the drogen should be stopped.
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5 mg—bottles of 50 scored tablets.
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For additional product information, see Upjohn representative or consult the packa circular.

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NEWS HIGHLIGHTS

UW Center for Health Sciences Names Vice-Chancellor

Regents of the University of Wisconsin System in January approved the appointment of Robert E. Cooke, MD to the new position of vice-chancellor of the Center for Health Sciences, Madison campus.

The appointment ended a two-year search for a nationally known administrator, teacher, and clinician to head the Center. Since 1970 the Center has included the schools of medicine, nursing and pharmacy, UW Hospitals, University Health Service, State Hygiene Laboratory, and Wisconsin Psychiatric Institute.

Dr. Cooke

Doctor Cooke is a professor of pediatrics at Johns Hopkins University, Baltimore, and pediatrician-in-chief at Johns Hopkins Hospital. He currently is on leave while serving as a visiting professor of preventive and social medicine at Harvard University. He will serve the University of Wisconsin on a part-time basis until he joins the faculty full-time July 1.

Wisconsin Society of Anesthesiologists Elects

At its annual fall meeting held at The Pioneer, Oshkosh, the Wisconsin Society of Anesthesiologists elected the following officers: president, Frederick J. Carpenter, MD,* Wauwatosa; president-elect, William H. Nicolaus, MD,* Green Bay; secretary, Ruth A. Stoerker, MD,* Madison; to the Board of Directors, John C. Koch, MD,* Berlin; delegate to the ASA, Ernest O. Henschel, MD,* Milwaukee; alternate delegates to the ASA, William H. Nicolaus, MD,* and Philip A. Hoffman, MD;* delegate to the State Medical Society of Wisconsin, Robert E. Holzgrafe, MD,* Waukesha.

The well attended meeting featured speakers Brian Craythorne, MD of the Department of Anesthesia, University of Cincinnati, and Burnell Brown, MD of the Department of Anesthesia, University of Arizona, and Doctor Holzgrafe.

Kenosha County Medical Society Elects

Louis Olsman, MD* of Kenosha was elected president of the Kenosha County Medical Society during its annual business meeting in December. He succeeds Frank C. Williams, Jr., MD.* Clifton E. Peterson, MD* was elected president-elect, to take office in January 1974. Others elected include: Raymond G. Welsch, MD,* and Gene F. Armstrong, MD,* as delegates to the State Medical Society's House of Delegates. MDs Walter C. Rattan* and John N. Richards* were named alternate delegates; all of Kenosha.

Guests at the meeting were Representatives George Molinaro and Eugene Dorff who discussed legislation pertinent to health care in Wisconsin. State Senator Douglas LaFollette briefly addressed the group. A summary of the final report of the Governor's Health Planning and Policy Task Force was given by Earl R. Thayer, secretary of the State Medical Society and a member of the Task Force. Of major interest in the report was the proposal for a three-man "health services commission" which would utilize a public utility concept for the regulation of health care in the state. Mr. Thayer was author of a minority report opposing this recommendation. (An index and summary of the Task Force recommendations appeared in the January "Blue Book" issue.

PHYSICIAN BRIEFS

Arthur F. Garcia, MD*

. . . Cedarburg, recently opened his office in Thiensville. Doctor Garcia graduated from the University of Illinois in 1966 and served his internship at Milwaukee County Hospital. His residency in ophthalmology was in the former Marquette Teaching Hospitals program (now the Medical College of Wisconsin). He recently completed two years military service in the U. S. Public Health Service at the National Eye Institute, National Institutes of Health, Bethesda, Md.

Francis G. Dahlke, MD

. . . Two Rivers, recently became associated with Doctors Clinic Ltd., Two Rivers. Doctor Dahlke graduated from George Washington University School of Medicine, Washington, D. C. in 1961 and served his internship and residency at George Washington University Hospital. He was chief surgical resident in the Department of General and Thoracic Surgery at the District of Columbia General Hospital, as well as chief surgical resident at George Washington University Hospital. He completed two years in the United States Air Force and was chief of the thoracic section at Elmendorf Hospital, Alaska.

Martha Rosin, MD

. . . formerly of Chicago, Ill., recently moved to Sturgeon Bay to practice medicine on a "part-time" basis. She will be associated with Door County Memorial Hospital. Doctor Rosin graduated from Albert Ludwig University Medical School, Freidburg, Germany, and established a general practice in Hamburg. She came to the United States and served an internship at Mt. Sinai Hospital, Chicago, and maintained a practice of medicine there from 1942 until 1972 when she became a permanent resident in Door County.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

PHYSICIAN BRIEFS . . .

Doctor Wilkinson

J. Francis Wilkinson, MD*

. . . Oconomowoc, recently "cut the ribbon" at the dedication ceremony of the Dr. J. Francis Wilkinson Wing of the Wilkinson Clinic in Oconomowoc. Doctor Wilkinson is observing his 50th anniversary of medical practice this year. (Photo courtesy of OCONOMOWOC ENTERPRISE)

Stanley N. Graven, MD*

. . . Madison, recently was appointed to the National Task Force on Perinatal Care. The Task Force, jointly sponsored by the AMA, American College of OB–GYN, American Academy of Pediatrics, and the American Academy of Family Physicians, is funded by the National Foundation March of Dimes. Doctor Graven is chairman of the section on personnel for the Task Force.

Thomas J. Cox, MD*

. . . Milwaukee, recently was installed as president of the Milwaukee Catholic Physicians' Guild. MDs John A. Kelble,* Milwaukee, was elected to the board of directors, Frank Falsetti,* Elm Grove, was named president-elect, and Donald J. Heyrman,* Menomonee Falls, secretary-treasurer. Other members of the board are MDs Paul J. Lawler,* Wauwatosa, and Steve L. Chojnacki,* Milwaukee.

NEWS HIGHLIGHTS . . .

Wisconsin Dermatological Society Elects

The Wisconsin Dermatological Society met November 18 at the Milwaukee County General Hospital. Nineteen dermatological patients were examined and discussed with the Society's guest, Dr. Peter Lynch, associate professor of dermatology at the University of Michigan.

New officers elected are: president, Robert B. Pittelkow, MD,* Milwaukee; vice-president, Hubert V. Moss, MD,* Madison; and secretary-treasurer, Stephen B. Webster, MD,* La Crosse.

Sacred Heart Rehabilitation Hospital Accredited

Sacred Heart Rehabilitation Hospital in Milwaukee has been granted a full three-year accreditation for its program of physical restoration by the Commission for the Accreditation of Rehabilitation Facilities (CARF). The Commission was established in 1967 after seven years of intensive work by the Association of Rehabilitation Centers, the National Association of Sheltered Workshops, and the Federal Office of Social and Rehabilitation Services. Sacred Heart began its transition from a sanitarium, or treatment facility, to a rehabilitation hospital seven years ago. The 66-bed hospital treats only patients with physical disabilities who have the potential for improvement.

Rural Nursing Study Gains Momentum

Planning for Rural Nursing (PRN), a research project which will allow nurses, physicians, members of other health planning groups, and consumers to study characteristics of nursing in rural areas of Wisconsin and six other states in the midwest gained momentum late last year when representatives from these groups met in Madison to participate in the regional planning initiated by nurses from the original seven states in November 1971.

To facilitate continued planning between and among interested state groups, the Division of Nursing, National Institutes of Health, contracted to finance regional planning through the Minnesota Nurses Association, and in July 1972 a study of rural nursing was launched in the states of Iowa, Michigan, Minnesota, Montana, North Dakota, South Dakota, and Wisconsin.

Each state has an established planning group or Core Committee, and elected representatives from each Core Committee serve as members of an Executive Committee, the body responsible for determining the direction and scope of the project.

On a national level, PRN will serve as a demonstration model for regional planning for the Division of Nursing, NIH. Outcomes of the various stages and phases of the planning process will be studied and evaluated. An end result will be development of guidelines for regional planning.

The following groups are represented on Wisconsin's State Core Committee:

Association of Licensed Practical Nurses, Commission on Statewide Planning for Nursing Education, Comprehensive Health Planning, Division of Health, Hospital Association, League of Nursing, Medical Society of Wisconsin, Nursing Home Association, Regional Medical Program, Board of Nursing, and Nurses Association.

Miss Kay Horswill, assistant professor of clinical nursing, University of Wisconsin and assistant nursing coordinator, Wisconsin Regional Medical Program, is chairman of Wisconsin's State Core Committee and the State's representative to the Executive Committee.

NEWS HIGHLIGHTS . . .

Dr. Gordon New Officer of Interstate

Edgar S. Gordon, MD,* professor of medicine at the University of Wisconsin–Madison Medical School, has been named president-elect of the Interstate Postgraduate Medical Association at its 57th Annual Scientific Assembly, held at the Washington–Hilton Hotel, Washington, D.C., November 13–16.

Dr. Gordon

The Interstate Assembly is one of the oldest scientific teaching programs directed to family physicians in the United States and Canada. It annually attracts some 1200 family physicians to its four-day meeting.

Doctor Gordon will serve as president when the Association meets in Hollywood, Fla., in November 1974. The 1973 Assembly will be held at the Palmer House in Chicago October 29 to November 1 with Dr. Rubin Flocks of Iowa City serving as president.

Many members of the Wisconsin faculty have spoken on previous Interstate Assembly programs. In recent years frequent lecturers have been MDs Ovid O. Meyer,* John F. Morrissey,* and Anthony R. Curreri* as well as Doctor Gordon.

Operation of Interstate rests in nine trustees, three of whom are from Wisconsin: MDs John M. Bell,* Marinette; William B. Hildebrand,* Menasha; and N. Alfred Hill,* Madison. For many years Dr. Erwin R. Schmidt, former chairman of the Department of Surgery of the University of Wisconsin Medical School, served as a trustee.

Roy T. Ragatz of the UW–Extension's Department of Postgraduate Medical Education has been the Association's executive director since 1954, succeeding Dr. Arthur Sullivan of Madison.

MCW Students Rank Fifth in Nation

Students at the Medical College of Wisconsin (MCW) have placed fifth in the nation in the 1972 Basic Science Examinations of the National Board of Medical Examiners. More than 9,000 second-year students in 87 medical colleges throughout the country took the six Basic Science Examinations of the National Board of Medical Examiners in 1972. There were 106 second-year MCW students. Their average scores placed the Medical College fifth in the nation.

Tri-County Medical Society Elects Officers

Newly elected officers of the Tri-County Medical Society of Eau Claire–Dunn–Pepin counties for the year 1973 are: president—George E. Owen, MD;* vice-president—Louis H. Frase, MD;* and secretary-treasurer—Peter H. Ullrich, MD,* all of Eau Claire.

Catherine Chambers, RN Retires

After 29 years of state service, Catherine Chambers, RN retired as an occupational health consultant with the State Division of Health, Department of Health and Social Services, at the end of 1972.

Her outstanding and sustained efforts to better occupational health nursing practices are well known not only in Wisconsin but also throughout the country. She has worked closely with the State Medical Society and the Wisconsin Nurses Association as well as other groups in establishing guidelines for occupational health programs that are widely used as basic references in and outside the state of Wisconsin.

PHYSICIAN BRIEFS . . .

Carl Zenz, MD*

. . . medical director of Allis–Chalmers Corp., West Allis, in November was elected a vice-president of the American College of Preventive Medicine at its 19th annual meeting in Atlantic City, N. J. Doctor Zenz will represent occupational medicine, one of four preventive medicine subspecialties represented by vice-presidents.

Robert A. Bonebrake, MD*

. . . Madison, rheumatologist at the Jackson Clinic, recently was the guest speaker at the quarterly membership meeting of the Southern District/Wisconsin Arthritis Foundation. His topic was "Current Concepts of Drug Therapy in Rheumatic Diseases." Doctor Bonebrake is vice-chairman of the Southern District/Wisconsin Arthritis Foundation.

Roland A. Pattillo, MD*

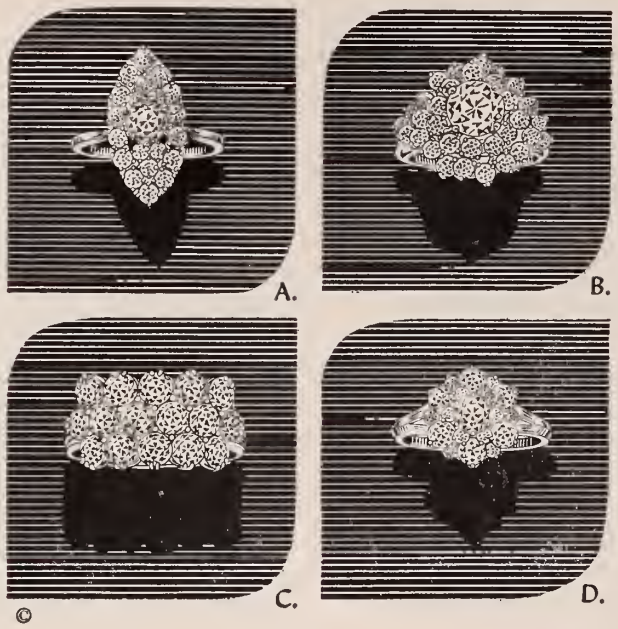
. . . Milwaukee, associate professor of gynecology and obstetrics at the Medical College of Wisconsin and director of MCW's cancer research and reproductive endocrinology laboratories, recently was appointed to the Atomic Energy Commission advisory committee on cancer.

John W. Gildersleeve, MD

. . . Marshfield, recently joined the medical staff of the Marshfield Clinic. A 1967 graduate of the University of Wisconsin Medical School, Doctor Gildersleeve interned at Blodgett Memorial Hospital, Grand Rapids, Mich., and served his residency at the Mayo Clinic, Rochester, Minn., and Virginia Mason Hospital in Seattle, Wash. He also served in the U. S. Army in Kwang Tri Province, Vietnam, and at Letterman Hospital, San Francisco.

Robert F. Schilling, MD

. . . Madison, professor of medicine at the University of Wisconsin Medical School, recently was elected president of the Central Society for Clinical Research at the group's annual meeting held in Chicago.



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C. Three rows of diamonds, total weight 1.66 ct. $1250
D. Cluster of diamonds, total weight 1 ct. ..... $ 750

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PHYSICIAN BRIEFS . . .

Michael J. Miech, MD*

. . . Menomonie, recently wa elected president of the Memoria Hospital medical staff. MDs Rob ert F. Burgfechtel,* Menomonie and Phil Limberg,* Glenwoo City, were elected president-elec and secretary, respectively.

John H. Renner, MD*

. . . Madison, director of th Family Practice Program at th UW Center for Health Sciences recently was appointed chairma of the Research Committee fo the Society of Teachers of Famil Medicine.

Thomas M. O'Connor, MD*

. . . Milwaukee, recently wa granted Fellowship in the American College of Cardiolog (ACC), the national medical society for specialists in cardiovascular diseases. MD John H. Huston,* Milwaukee, the ACC Governor for Wisconsin, made the announcement.

Frederic M. Blodgett, MD*

. . . Milwaukee, professor of pediatrics at the Medical College of Wisconsin, Milwaukee, recently was elected chairman of the Committee of the Section on Community Pediatrics of the American Academy of Pediatrics.

Philip T. White, MD*

. . . who was associate dean of the Medical College of Wisconsin in Milwaukee, has moved to Texas where he joined the Scott & White Clinic January 1. As chairman of the department of neurology, Doctor White will have primary responsibility in patient care. He will continue to teach, however, in a less demanding capacity. Doctor White joined the MCW faculty seven years ago, spending the first five as professor and chairman of the department of neurology and the last two as associate dean. During his administrative years, Doctor White enlarged the MCW's role as a provider of allied health education in view of local and national needs for increased allied health personnel.

NEWS HIGHLIGHTS . . .

Heart Association Notes Doctor Lange's Services

At a meeting in October 1972 the Board of Directors of the Wisconsin Heart Association unanimously passed a resolution in recognition of the services of Ramon L. Lange, MD who died Aug. 20, 1972 in Elm Grove. Doctor Lange's untimely death came at the height of his career as professor of medicine at the Medical College of Wisconsin, Milwaukee. The resolution follows:

WHEREAS, the Wisconsin Heart Association notes with sincere regret the untimely passing of Ramon L. Lange, M.D.; and

WHEREAS, Dr. Lange served the Wisconsin Heart Association for nearly a decade, as a member of its Board of Directors from 1965–71, as chairman of its Research Committee in 1968–69, and as a member of other committees including Budget & Finance, Legislative Advisory, Physician Education and Executive; and

WHEREAS, Dr. Lange, as Professor of Medicine at the Medical College of Wisconsin and as a devoted researcher, demonstrated his continued dedication to the conquest of cardiovascular disease;

NOW, THEREFORE BE IT RESOLVED that we, the Directors of the Wisconsin Heart Association, on October Eighteenth, Nineteen Hundred and Seventy-Two, extend our deepest sympathy in the loss of Ramon L. Lange, M.D., our former co-worker and friend.

(signed) SAM N. SHERMAN
Chairman of the Board

JOHN H. MORLEDGE, M.D.
President

MARGARET ANDERSON, R.N., M.S.N.
Secretary

Marshfield Clinic Names Manager of Communications

The new post of Manager of Communications at the Marshfield Clinic in Marshfield will be assumed by Peter A. Kirsch February 1, it was announced by James M. Ensign, executive director of the Clinic.

Mr. Kirsch has served as Director of Public Information for the Wisconsin Regional Medical Program (WRMP) since 1968. He will manage the Clinic's internal and external communications programs, including new programs aimed at informing employees, consumers, and health professionals of important developments occurring at the 116-physician Clinic and the Marshfield Clinic Foundation for Medical Research and Education.

Mr. Kirsch is a 1959 graduate of the Marquette University College of Journalism. He received his Master's Degree in Communications from the University of Wisconsin–Milwaukee in 1971. He is chairman of the Advisory Committee to the Wisconsin State Board of Nursing and vice-president and past president of the Sacred Heart School of Practical Nursing in Milwaukee. He is treasurer of the Wisconsin Chapter of the Public Relations Society of America, and has served in various capacities with the Comprehensive Health Planning Agency for Southeastern Wisconsin.

Health Professionals Discuss Rheumatic Disease

"The Role of Health Professionals in Pre- and Post-Operative Care of Rheumatic Disease Patients" was discussed January 20 at a workshop session of the Allied Health Professions Section, Arthritis Foundation of Wisconsin.

Robert A. Bonebrake, MD,* chief of the rheumatology section at the Jackson Clinic, Madison, and Harvey L. Barash, MD,* an orthopedic surgeon at the Jackson Clinic, presented case histories.

Over 100 members of the Section attended the group's winter meeting at the Methodist Hospital in Madison. The meeting was open to all health professionals concerned with rheumatic and connective tissue diseases.

PHYSICIAN BRIEFS . . .

Doctor Spernoga

John F. Spernoga, MD

. . . Washburn, recently became associated with MDs Harry H. Larson* and John G. Telford* of Washburn. He graduated from St. Louis University School of Medicine in 1967 and served his internship and residency at St. Louis University Hospital and in Minneapolis. Prior to coming to Washburn, he was in the United States Army. (Photo courtesy of WASHBURN TIMES)

Elmer P. Rohde, MD*

. . . has closed his medical practice in both his Galesville clinic and the Holmen branch office. He is now associated with the family practice section of the Skemp–Grandview Clinic in La Crosse. Doctor Rohde, a State Medical Society councilor, had been in his Galesville location since 1948. He continues to reside in Galesville. C. B. Moen, MD* continues to maintain hours at the clinic in Galesville so that the community will not be without the services of a physician.

Irvin M. Becker, MD*

. . . Milwaukee, clinical professor of internal medicine at the Medical College of Wisconsin, recently was appointed chief of the medical staff at Mount Sinai Medical Center.

PHYSICIAN BRIEFS . . .

Edward J. Wilkinson, MD*
James Q. Whitaker, MD*

. . . Milwaukee physicians at the Medical College of Wisconsin, have been granted American Cancer Society support for special training in treating cancer patients. Doctor Wilkinson is a research fellow in MCW's Department of Pathology; Doctor Whitaker, a resident in pathology at Milwaukee County General Hospital. They each were awarded $4,800 in clinical fellowships.

Harris A. Weisse, MD*

. . . of Plymouth has informed the State Medical Society that he is retiring, at the age of 52, after practicing medicine and surgery for 26 years in Wisconsin. The doctor and his wife ordered a ketch built in Taiwan and plan on sailing the Seven Seas with probably the first year spent in the Caribbean. The vessel was to be delivered in the United States in January. Because of indefinite plans for the future concerning the Weisses' return to the U.S., Doctor Weisse resigned from the American College of Obstetrics and Gynecology (after 20 years as a fellow) and the International College of Surgeons (abdominal surgery). He has been placed on the inactive list of the American Society of Abdominal Surgeons. Doctor Weisse also resigned his memberships in the Sheboygan County Medical Society, State Medical Society of Wisconsin, and American Medical Association. His three partners in the Plymouth Clinic, MDs Lloyd J. Steffan* and Ricardo J. Alvarez,* and DO William G. Treviranus, Jr. have been actively seeking a replacement.

Luis G. Camacho, MD

. . . Neenah, formerly a surgeon at the Mayo Clinic, Rochester, Minn., recently joined the medical staff of the Riverside Clinic. He attended the National University of Cordoba, Argentina, Medical School and served his internship in Argentina and Chicago.

NEWS HIGHLIGHTS . . .

Milwaukee Society Has New Officers

A Milwaukee neurologist, Jules D. Levin, MD* assumed the presidency of the Medical Society of Milwaukee County January 1, succeeding David J. Carlson, MD.* The new president-elect is Donald P. Babbitt, MD,* a radiologist who will assume the presidency Jan. 1, 1974. George F. Flynn, MD,* a surgeon, is the secretary-treasurer.

At its annual meeting in December MDs Christopher R. Dix,* retiring member of the board of directors and past president of the Society, and Thomas F. Jennings,* also a retiring member of the board, were presented certificates of recognition by the County Society.

Also at this meeting the Society presented radio station WISN its Medical Scribe Award for journalism excellence. The station was cited for its continuing broadcast of the "Sound of Medicine" programs, which started in 1966.

Wood County Medical Society Meets

Twenty-seven members of the Wood County Medical Society met November 30 in Marshfield. Guest speaker was Judge Herbert Bunde of Wisconsin Rapids. Glenn Waldschmidt, field representative for the State Medical Society of Wisconsin, also was a guest.

New Officers Named for Wisconsin Section of ACOG

New officers of the Wisconsin Section of the American College of Obstetricians and Gynecologists are: MDs William V. Luetke* of Madison, chairman, and Samuel G. Perlson* of Milwaukee, vice-chairman. They were elected to three-year terms.

Milwaukee Academy of Medicine Installs New Officers

The Milwaukee Academy of Medicine at its 87th Annual Meeting January 16 at the University Club of Milwaukee installed the following officers for 1973: president, Donald P. Babbitt, MD;* president-elect, Harold F. Hardman, MD;* vice-president, Donald A. Roth, MD;* secretary, William A. Kretzschmar, MD;* treasurer, David V. Foley, MD;* and librarian, Sanford R. Mallin, MD.*

Dr. Charles Reed Elected Allergy President

On February 13 Charles E. Reed, MD* of Madison became the president of the American Academy of Allergy at ceremonies held in the Washington Hilton during the Academy's annual meeting. Doctor Reed now heads a 2000 member organization, the largest scientific group of its kind in the world devoted to the diagnosis, treatment, and study of allergic diseases.

Doctor Reed is professor of medicine at the University of Wisconsin Medical School in Madison. He also is director of the School's Allergic Disease Center and program director of an Allergy–Immunology Training Grant. As a research scientist, he has since 1965 studied various allergic diseases including asthma, hay fever, and more recently hypersensitivity pneumonitis. He has authored and coauthored some 49 scientific papers describing his research.

A 1945 graduate of Columbia University College of Physicians and Surgeons in New York City, Doctor Reed served in the Medical Corps of the U.S. Army, completed a residency in Internal Medicine, and in 1951 began a career which now spans 22 years and includes teaching, private practice, and research in allergy. He came to Wisconsin in 1961. From 1969 to 1972, he was historian for the Academy; and in 1971 he was elected co-chairman of the Conjoint Board of Allergy and Immunology.

Snowmobile Symposium Held at Marshfield

Surgeons who have conducted in-depth snowmobile accident research in Michigan, Minnesota and Wisconsin have called for a three-pronged program aimed at reducing injury in the rapidly growing snowsled sport.

Those attending the December 2 symposium on the medical aspects of snowmobile safety sponsored by the Marshfield Clinic Foundation were told the recommendations designed to minimize injuries stressed "three E's", engineering, education, and enforcement.

Phase one of the suggested program would require the cooperation of manufacturers to design and build a safer snowmobile, as well as improved helmets and face shields.

The educational phase would stress training sessions for snowmobile users. The skills of proper driving techniques would be emphasized.

Finally, policing of snowmobile activity was recommended. The general agreement was that a solid law enforcement policy, while hard to implement, would be essential for the success of the overall accident reduction program.

The day-long symposium was attended by doctors, law enforcement officers, members of the Governor's Snowmobile Council, Department of Natural Resources officials, and representatives of snowmobile clubs, manufacturers, distributors, and dealers. Moderator for the session was James M. Ensign, Marshfield Clinic executive director.

The need for safer operation of snowmobiles was made clear during the Symposium's morning session when six different doctors presented their research findings, gained from treating snowmobile accident injuries.

Speaking were DDS Richard A. Peters, and MDs David J. Ottensmeyer,* and Fred B. Bersalona,* all of the Marshfield Clinic. Also addressing the group were MDs Larry J. Sell, Manistique, Mich.; George Pratt,* Rhinelander; and James J. Mongé, Duluth, Minn.

The afternoon portion of the symposium included Wisconsin Representative, John Oestreicher from Marshfield. He spoke on the new comprehensive state snowmobile bill that will regulate certain aspects of the sport for the first time this season.

One of the most important segments of the bill created the Governor's snowmobile council, a group of 15 who will study the sport and make legislative suggestions. The bill also provides for the building of snowmobile trails throughout the state.

Rounding out the program was a panel discussion on snowmobile legislation, safety and education. Representatives from the Wisconsin Department of Natural Resources, the Governor's Snowmobile Council, the Trees for Tomorrow Conservation organization, snowmobile clubs and manufacturers and the medical research group participated.

The Wisconsin Governor's Snowmobile Recreation Council met in Marshfield the night before the Symposium. The group formed an ad hoc committee, headed by Frederick J. Wenzel, Marshfield Clinic Foundation executive director, to investigate safety and environmental problems, and to suggest how research in these areas should be funded and carried out. In part, the Council expects to work closely with the Wisconsin Legislature in developing comprehensive snowmobile laws that will promote the safe use of the machine.

Your attention is called to the scientific article, "Snowmobile Accidents in Central Wisconsin," which appears elsewhere in this issue.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1973

2 Dane County Medical Society Board of Trustees
4 Advisory Group, Wisconsin Regional Medical Program
8 State Pharmacy Board Exams
8 Dane County Medical Society Insurance Advisory Committee
8 Dane County Medical Society Utilization Review Plan
9 State Pharmacy Board Exams
9 Madison Anesthesiology Society
10 SMS Commission on Safe Transportation
10 SMS Division on Aging
11 Madison Academy of Internal Medicine
15 Faculty and Junior Students, University of Wisconsin Medical School
15 Dane County Medical Society Insurance Advisory Committee
16 Steering Committee, Wisconsin Emergency Services Program
17 Staff, Wisconsin Division of the American Cancer Society
18 SMS Commission on Hospital Relations and Medical Education and Joint Practice Commission
19 SMS Committee on Peer Review
20 Board of Directors, Wisconsin Health Care Review, Inc.
23 Dane County Medical Society Ad Hoc Committee on Foundations
23 Dane County Medical Society Advisory Committee to County Health Agencies
24 SMS Committee on Occupational Health
25 SMS Division on Ear, Nose and Throat
26 Wisconsin Otolaryngological Society
27 Wisconsin Otolaryngological Society
27 Executive Committee of SMS Council

Meetings not held in the Society "Hame" but which have a direct relationship are printed in italics with the location in parentheses.

PHYSICIAN BRIEFS . . .

Simeon B. Ortiz, MD

. . . recently became associated with Dr. Harold Werbel* at the Badger Medical Center, Delavan. A native of the Philippines, he graduated from the Far Eastern University in Manila, served an internship at Milwaukee Deaconess Hospital and a residency at Worcester City Hospital, Worcester, Mass. Doctor Ortiz received a fellowship in cardiopulmonary medicine at the Veterans Administration Hospital in St. Louis, Mo., and also served two years in Laos with Operation Brotherhood, a volunteer organization financed by the United States, The Philippines, and Laos. Prior to coming to Delavan, he was a house physician at Doctor's Hospital in Milwaukee.

Elizabeth Miller, MD

. . . a noted cancer researcher, has been appointed acting director of McArdle Laboratory for Cancer Research, University of Wisconsin–Madison Medical School. She succeeds Harold P. Rusch, MD who was named director of the new Wisconsin Clinical Cancer Center at the UW Center for Health Sciences in September. She also was appointed as acting director of the Department of Experimental Oncology. The new director's main area of research has been in the field of chemical carcinogenesis —the study of the means by which tumors are induced by chemicals.

Nyles R. Eskritt, MD

. . . Stevens Point, recently became associated with the Rice Clinic in the department of dermatology. He graduated from the University of Wisconsin Medical School in 1966 and completed his internship at C. T. Miller Hospital, St. Paul, Minn. He served in the United States Air Force as a flight surgeon for two years and took his residency at the University of Minnesota Department of Dermatology, Minneapolis. Doctor Eskritt, prior to joining the Rice Clinic, completed a preceptorship at the Marshfield Clinic.

NEWS HIGHLIGHTS . . .

Northpoint Medical Complex Planned in Milwaukee

A $2 million fund drive for development of the Northpoint Medical Complex in Milwaukee was completed in September. Seven years in the planning, the complex will house St. Mary's Hospital, a rehabilitation hospital, and a psychiatric hospital, as well as diagnostic and ambulatory services and physicians' offices. Present buildings on Lake Drive and Terrace Avenue, as well as a new $20 million hospital facing the old St. Mary's on Lake Drive will all be utilized in an effort to coordinate patient care and hold the line on costs, it was reported.

Montello Clinic Has Open House

The 20-room, $73,000 Montello Clinic staged an open house in October for almost 800 people. The clinic building was financed through donations. The waiting room was furnished and dedicated in memory of the late Dr. R. F. Inman. The community is hopeful that two doctors and a dentist will be attracted to the new health care facility.

Lakeland Memorial Hospital Agrees to Grant Terms

In late October the Lakeland Memorial Hospital Association, Inc. voted unanimously to agree to terms in the will of New York art dealer, S. Howard Young enabling the hospital to receive a bequest of about $20 million from Mr. Young's estate.

Mr. Young had spent many summers at his home near Minocqua. He also had been cared for in the Woodruff hospital over the years. According to the will, the hospital had to agree to several conditions in order to receive the grant. The American Hospital Association has said that Mr. Young's bequest is the largest to a single, rural hospital recorded in its history.

UW Medical Students Awarded Grants

Three senior medical students at the University of Wisconsin–Madison have been awarded grants that will help pay travel expenses to 3-month learning externships at missionary hospitals in Nicaragua and the Congo region of Africa.

They are Raymond R. Johnson, Madison, and Miss Susan Palmer, Fond du Lac, who will study and participate in community health care programs at Thaeler Memorial Hospital in Nicaragua, and T. S. Danielson, Grantsburg, who will study at facilities in Zaire in the former Belgian Congo. Messrs. Johnson and Danielson left in November and Miss Palmer, in December.

The grants were among 37 awarded competitively by Medical Assistance Programs–Readers Digest International Fellowships for 1972–73, according to Ned Wallace, MD, director of international health affairs at Wisconsin. Students selected receive three-fourths of their round-trip air fare to their externship as a scholarship grant.

New UW School of Nursing Granted $4.2 Million

The National Institutes of Health has granted $4.2 million in federal funds for School of Nursing construction at the University of Wisconsin–Madison. This is part of $14.9 million in federal grants to the Health Sciences Center on the Madison campus.

ENT Referral Clinic Opens in Watertown

An ear, nose, and throat referral clinic has been opened on a part-time basis in Watertown Memorial Hospital with Timothy J. Donovan, MD* of the Dean Clinic in Madison in charge. Doctor Donovan is associated with MDs Philip Dibble* and Edward Johnson. □

Dean A. Emanuel, MD*

. . . head of the Farmer's Lung research project of the Marshfield Clinic Foundation for Medical Research and Education, has received a $22,944 federal grant for continued study of the disease. These funds from the National Institute for Occupational Safety and Health will be used to develop a model system of the disease in animals. This marks the 13th year of funding for the study at the Clinic. Associated with Doctor Emanuel on this Farmer's Lung research program is Marshfield Clinic physician, Dr. James Marx.

George A. Hellmuth, MD*

. . . professor of physiology at the Medical College of Wisconsin and director of the Heart Rehabilitation Center at Curative Workshop, recently received a $10,000 grant from the Fraternal Order of Eagles to be used in the preparation of a book on the primary prevention of heart attack. The book will be a major effort to educate and motivate the consumer to change his living habits to help prevent heart attacks. Doctor Hellmuth will edit and co-author the book, which is to be based in part on the proceedings of a recent symposium held in Milwaukee on consumer health education and primary prevention of heart attack.

Edward J. Lennon, MD*

. . . associate dean of the Medical College of Wisconsin, Milwaukee, will be the MCW coordinator of a study grant of $262,639 from the National Cancer Institute to develop plans for a proposed Radiation Therapy Research and Patient Care Network in Southeastern Wisconsin. The network's objective will be to coordinate the delivery of comprehensive radiation treatment and diagnostic services to Milwaukee and Southeastern Wisconsin residents. MCW will work with its affiliated hospitals and other interested community health agencies in planning the network. Doctor Lennon will be assisted initially by a ten-member planning committee which will include James E. Youker, MD,* chairman of MCW's Department of Radiology, and Frank Ellis, MD, professor of and director of Radiation Therapy at Milwaukee County Medical Complex. Doctors Youker and Ellis were key figures in the request for the grant to MCW and in the subsequent award.

Ha Gun Lee, MD
Velayudhan K. Nair, MD

. . . Monroe, recently became associated with the staff of The Monroe Clinic. Doctor Lee, a graduate of Yonsei University Medical School, Korea, has joined Hushang Najat, MD* in the Department of Orthopedic Surgery. He took his training at the University of Wisconsin Medical School in Madison. Doctor Nair, a graduate of National Medical College, Bombay, India, joined Benjamin H. Brunkow, MD* in the Department of Urology. He took his residency training at Huron Road Hospital, Cleveland, Ohio.

Anthony R. Curreri, MD*

. . . has been named the Evan P. Helfaer Distinguished Professor of Surgery at the University of Wisconsin Center for Health Sciences, Madison campus. He also is associate vice chancellor in the Center. Doctor Curreri will hold an endowed professorship established last spring by retired Milwaukee industrialist Evan P. Helfaer, a 1920 UW chemistry graduate who founded Lakeside Laboratories and was president of that firm until its purchase in 1959 by Colgate–Palmolive.

Michael P. Mehr, MD*

. . . Marshfield, recently joined the medical staff of the Marshfield Clinic. Doctor Mehr graduated from Georgetown University Medical School in Washington, D. C. and interned at Colorado General Hospital at the University of Colorado, Denver. His first year of residency was served at Brooke General Hospital, Ft. Sam Houston, Tex., and the next two years he was a captain in the medical corps of the U. S. Army. Prior to joining the Clinic, he was in residency at Milwaukee County General Hospital and in practice with Earl Shulz MD* of Waukesha.

Robert D. Argand, MD*

. . . Madison, recently became associated with Lawrence T. Giles, MD* in the practice of internal medicine. He graduated from the State University of New York and served his internship at Kings County Hospital, Brooklyn. Doctor Argand completed his residency at University Hospitals, Madison.

Charles H. Raine, MD

. . . Racine, joined the medical staff of the Kurten Medical Clinic in Racine. A native of Selma, Ala., Doctor Raine is a graduate of Meharry Medical School. Prior to joining the Kurten Medical Clinic, he was in the U. S. Air Force where he served as Chief of Internal Medicine and Chief of Hospital Services.

Vitoldas Balciunas, MD*

. . . Kenosha, and his wife in January attended the inauguration of President Nixon and events related to it. Both are natives of Lithuania. They are active in political education of ethnic groups. Lithuanian dancers from Chicago performed at the Kennedy Center and another group participated in the inaugural parade.

H. Gladys Spear, MD*

. . . Milwaukee psychiatrist, has asked for a correction in a "Physician Briefs" item concerning her career which appeared in the December 1972 issue. The item stated that she had spent 15 months at the Chicago Institute for Psychoanalysis whereas she actually had spent a 15 months residency at the Illinois Psychiatric Institute, part of which was spent at the Institute for Juvenile Research. □

OBITUARIES

Herbert F. Wolters, MD, 83, Milwaukee, died Oct. 1, 1972 in Milwaukee.

Born Jan. 3, 1889 in Iowa County, Wis., Doctor Wolters graduated from St. Louis University School of Medicine in 1912 and served his internship at the St. Louis City Hospital. Doctor Wolters served in the United States Medical Corps during World War I.

Surviving are his widow, Eleanor; a son, Allan, Miami, Fla., and a daughter, Janet, Milwaukee.

Jack S. Ackerman, MD, 76, Milwaukee, died Nov. 9, 1972 in Milwaukee.

Born on Aug. 9, 1896 in what is now Czechoslovakia, Doctor Ackerman graduated from Karl Ferdinand University School of Medicine, Prague, Czechoslovakia. He came to the United States and Milwaukee in 1923. In 1924 he served his internship at Mt. Sinai Hospital in Milwaukee. In 1929–30 he did postgraduate work in gynecology in Budapest, Hungary, and Vienna, Austria.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. He was on the staff of Mt. Sinai Medical Center.

Surviving are his widow, and one son, Dr. John M., a psychiatrist, of Santa Barbara, Calif.

M. Meredith Baumgartner, MD, 70, Janesville, died Nov. 13, 1972 in Janesville.

Born on Jan. 28, 1902 in Bluffton, Ohio, Doctor Baumgartner graduated from Rush Medical School, Chicago, in 1929 and served his internship and residency at Presbyterian Hospital, Chicago. Doctor Baumgartner was a member of the staff of Pember–Nuzum Clinic, Janesville, from 1931 until his retirement in 1966. He was on the medical staffs of Mercy Hospital, Rock County Hospital, and Pinehurst Sanitorium. Doctor Baumgartner served in the United States Navy during World War II at the Naval Hospital in Shoemaker, Calif. and on Samar, The Philippines.

He served as president of the Rock County Medical Society in 1952, was a preceptor in the Extern Program of the University of Wisconsin Medical School, and from 1955–58 was a member of the board of trustees of American Association of Medical Clinics.

He was a diplomate of the American Board of Internal Medicine, a member of American College of Chest Physicians, American College of Physicians, American Diabetes Association, Wisconsin Society of Internal Medicine, Chicago Institute of Medicine, American Society of Internal Medicine, and a former member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Helen; three daughters, Mrs. Frank Bostwick, Cincinnati, Ohio; Mrs. Roger White, Santa Monica, Calif.; and Mrs. Gilbert Sochouz, Dampierre, France.

Edward S. Carlsson, MD, 81, La Crosse physician for 50 years, died Nov. 14, 1972 in La Crosse.

Born on July 24, 1891 in Lindsborg, Kan., Doctor Carlsson graduated from Rush Medical College in 1918 and served his internship at Lutheran Hospital, La Crosse. In 1920, he was a co-founder of the Gundersen Clinic along with the late Drs. Adolph Gundersen, Christian Christianson, and Gregor Smedal. In 1968, he retired from practice and was honored into the "50 Year Club" of the State Medical Society of Wisconsin.

He was a member of the Wisconsin Society of Obstetricians and Gynecologists, the La Crosse County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Pernella; a daughter, Mrs. John Fisher, Beloit; two sons, John, St. Paul, Minn., and Edward S., Jr., who is administrator of the Gundersen Clinic.

Frederick G. Jensen, MD, 65, Menasha, died Nov. 28, 1972 in Menasha.

Born on Sept. 20, 1907 in Colby, Doctor Jensen graduated from New York University and Belleview Medical College in 1932 and served his internship at Bellevue Hospital, New York City.

He had practiced in Menasha since 1933 and was a former chief of staff at Theda Clark Memorial Hospital and a past president of the Winnebago County Medical Society. He served in the United States Navy during World War II and was a charter member of the American Academy of Family Physicians.

He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Barbara; three daughters, Mrs. Clarke Poad and Mrs. William Merizon, Neenah, and Mrs. Michael Doeren, Fish Creek.

Herbert Peter Weiland, MD, 81, Verona, died Dec. 3, 1972 in Madison.

Born on Sept. 20, 1891 in Baraboo, Doctor Weiland graduated from Loyola University, Chicago, in 1915 and served his internship at Madison General Hospital, Madison. Doctor Weiland had practiced medicine in the Verona area since 1921 and served for several years as house doctor for the Dane County Hospital and Home. He also was on the medical staff of St. Mary's, Madison General, and Methodist hospitals in Madison and St. Joseph's Hospital, Dodgeville.

Surviving are his widow, Calla, and a son, Burr, Madsion. □

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MEMBERSHIP REPORT AS OF DECEMBER 31, 1972

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Banerjee, Tarit K., 630 S. Central Ave., Marshfield 54449
Bercovici, Edwin B., 9001 N. 76th St., Milwaukee 53223
Burroughs, John T., 7635 W. Oklahoma Ave., Milwaukee 53219
Campbell, John T., 59 Racine St., Menasha 54952
Chatterjee, Amarendra N., 837 Clermont St., Antigo 54409
Chin, Jorge N., 519 N. 20th St., Milwaukee 53233
Condon, Robert E., 8700 W. Wisconsin Ave., Milwaukee 53226
Deffner, Norman F., 708 Grant St., Wausau 54401
Eisenberg, Carl S. L., 3003 W. Good Hope Rd., Milwaukee 53209
Eskritt, Nyles R., 2501 Main St., Stevens Point 54481
Field, H. Brenton, Jr., 3003 W. Good Hope Rd., Milwaukee 53209
Garcia, Arthur F., Jr., 210 N. Green Bay Rd., Thiensville 53092
Gildersleeve, John W., 630 S. Central Ave., Marshfield 54449
Ivsin, Rostislav, 182 S. Main St., Saukville 53080
Jacobsen, Paul M., 4655 Lyman Lane, Madison 53711
Kashnig, David M., 4801 Sheboygan Ave., Apt. 804, Madison 53705
Koch, Edgar L., 630 S. Central Ave., Marshfield 54449
Konz, Frederic S., 80 Sheboygan St., Fond du Lac 54935
Korns, Michael E., 8700 W. Wisconsin Ave., Milwaukee 53226
Lee, Frank Y. T., 605 W. 14th St., Marshfield 54449
Liao, Fu-Che, 630 S. Central Ave., Marshfield 54449
Majid, H. A. Abdul, 240 First St., Neenah 54956
Mayr, James F., 3637 S. 54th St., Milwaukee 53220
McIlroy, Gary T., 630 S. Central Ave., Marshfield 54449
Meyer, Paul G., 630 S. Central Ave., Marshfield 54449
Nandi, Manis, 100–15th Ave., South Milwaukee 53172
Nuenz–Gornes, Jesus F., 630 S. Central Ave., Marshfield 54449
Owen, Russell H., 2031 Regency Court, Appleton 54911
Parent, Kevin, 630 S. Central Ave., Marshfield 54449
Pilcher, Charles A., 128 Main St., Denmark 54208
Polender, Bruce A., 1836 South Ave., La Crosse 54601
Ray, Jefferson F., III, 630 S. Central Ave., Marshfield 54449
Saleem, Mohammad, 3975 N. 68th St., Milwaukee 53216
Salmon, Douglas D., 420 E. Longview Dr., Appleton 54911
Schwab, Jeffrey P., 1507 Doctors Court, Watertown 53094
Shaurette, Glen N., 1905 White Swan Dr., Oshkosh 54901
Stormo, Kenneth A., 270 Sheboygan St., Fond du Lac 54935
Strauss, George S., 630 S. Central Ave., Marshfield 54449
Thiru, Arunachalam, 5000 W. Chambers St., Milwaukee 53210
Wuchner, Edward J., 1912 Atwood Ave., Madison 53704

CHANGE OF ADDRESS

Aguila, Demetrio A., Jr., 630 South Central Ave., Marshfield 54449
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Appen, Richard E., 901 Sterns Hill Rd., Waltham, Mass. 02154
Argand, Robert, 746 West Main St., Apt. 205, Madison 53715
Atkins, F. Eliska, 400 Juneau Lane, Minneapolis, Minn. 55441
Bacon, Glenn A., 3748 Waldorf Dr., Dallas, Tex. 75229
Barbo, Dorothy M., 3300 Henry Ave., Philadelphia, Penn. 19129
Becker, Walter T., 400 East Thomas St., Wausau 54401
Belson, Michael J., P. O. Box 1348, Green Bay 54305
Bergwall, James C., 217 West Center, Hortonville 54944
Blank, Richard J., 3207 Walnut, Grand Forks, N. D. 58201
Borchardt, Ronald E., 1503 West Browning, Fresno, Calif. 93705
Brister, G. H., Hospital North—Maple Hill, Wausau 54401
Britton, Donald M., 6 Whitcomb Circle, Apt. 15, Madison 53711
Calvy, Thomas L., 8205 Rockway Pl., Milwaukee 53213
Carson, John P., Mid-Dakota Clinic, Bismarck, N. D. 58501
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Clarke, B. Earle, 3010 Foothill Rd., Santa Barbara, Calif. 93105
Curran, William P., 2821 Southwest 4th St., Boynton Beach, Fla. 33435
deOliveira, Mario M., 2040 West Wisconsin Ave., Milwaukee 53233
Edwards, Donald E., 937 Broadway, Cape Girardeau, Mo., 63701
Fenlon, Charles E., 620 East Longview Dr., Appleton 54911
Fick, Kenneth R., 2525 North Mayfair Rd., Milwaukee 53226
Galasinski, Roman E., Long Lake—Oneida County, Clear water Lake 54518
Gillespie, Malcolm E., Johnson Clinic, Maplewood, Minn. 55109
Go, Simplicio K., 836 North 12th St., Milwaukee 53233
Gollin, Frank F., 4513 Fox Bluff Lane, Middleton 53562
Hammes, George R., 400 East Thomas St., Wausau 54401
Herrington, Roland E., 2511 Broken Hill Court, Waukesha 53186
Hill, Nels A., 17105 Gulf Blvd., St. Petersburg, Fla. 33758
Hodges, Paul C., Jr., P. O. Box 112, Appleton 54911
Horkheimer, Ronald W., 9997 West North Ave., #179, Milwaukee 53226
Inhorn, Stanley L., 465 Henry Mall, Madison 53706
Janicek, Don R., 333 West Mifflin St., Madison 53703
Kalember, Robert L., Rock County Health Care Center, North Parker Drive, Janesville 53545
Kay, Eugene M., 73–020 Homestead, Palm Desert, Calif. 92260
Keller, Kent E., 615 South 10th St., LaCrosse 54601
Kennedy, Ralph O., 604 North Richmond, Appleton 54911
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Kohn, Samuel E., 2304 West Cumberland Court, 102N, Mequon 53092
Lanier, Patricia F., 2501 Belleview Rd., Upland, Calif., 91786
Lattos, William E., 1829 West Halsey, Milwaukee 53221
Locher, Wolfran G., 3326 North 11th St., Wausau 54401
Lu, Albert T., 1205 Cardinal Lane, Union Grove 53182
Lucas, Andrew M., 811 Wither, Wisconsin Rapids 54494
Lucas, George L., 2704 Marshall Court, Madison 53705
Mabini, Francisco, Jr., 5921 Sycamore, Greendale 53129
Mehr, Michael P., 630 South Central Ave., Marshfield 54449
Meyer, Glenn A., 16475 Shoreline Dr., Brookfield 53005
Mills, John M., P. O. Box 1348, Green Bay 54305
Morris, William G., 1850 Larsen Dr., Rhinelander 54501
Nadeau, E. George, Jr., P. O. Box 1348, Green Bay 54305
Nadeau, Emile G., P. O. Box 1348, Green Bay 54305
Nelson, Wallace L., Box 348-F, Route 1, Long Cove Rd., Waupaca 54981
Olsen, Leonard C. J., 230 Horizon East, Apt. 312, Boynton Beach, Fla. 33435
Pansch, Donald J., 211 North Commercial St., Neenah 54956
Petersen, Roger D., 600 South Dixie Highway, Boca Raton, Fla. 33432
Randall, Murray W., P. O. Box 133, Divide, Colo. 80814
Rater, Cornelius J., 2200 West Kilbourn Ave., Milwaukee 53233
Relacion, Jose R., 6290 North Port Washington Rd., Milwaukee 53217
Roth, Harry, 1025 Regent St., Madison 53715
Rush, Benjamin M., P. O. Box 94, Harmon, La. 71019
Samadani, Ayaz M., 130 Warren St., Beaver Dam 53916
Schmidt, John P., 9616 West Langlade, Milwaukee 53225
Schmidt, Robert T., P. O. Box 1348, Green Bay 54305
Smith, David A., 20 East Milwaukee St., Janesville 53545
Soifer, Morton M., 9466 North Broadmoor, Milwaukee 53217
Solochek, Sheldon M., 6074 North Kent Ave., Milwaukee 53217

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Spence, Clarence H., 1300 Canal St., #624, New Orleans, La. 70112
Springer, Vincent G., P. O. Box 442, Neenah 54956
Stergiades, Frank G., 2040 West Wisconsin Ave., #303, Milwaukee 53223
Stinson, H. Keith, 835 South Main St., Oconto Falls 54154
Tamayo, Alfonso G., 20–22 South 1st St., Sturgeon Bay 54235
Tamayo, Primo R., 2500 North Mayfair Rd., Milwaukee 53226
Tufts, Millard, 2525 South Shore Dr., Milwaukee 53207
Van Hecke, Leander J., 9132 Dixon St., Milwaukee 53214
Vedder, Charles A., 619 Laurel Court, Marshfield 54449
Wainscott, Paul E., 5602 East North Wilshire Drive, Tucson, Ariz. 85711
Wall, Thomas, 9202 West Hawthorne, Mequon 53092
Wallestad, Philip W., 1328 South Idaho Ave., Libby, Montana 59923
Welter, Donald J., 623 Canterbury Dr., Augusta, Ga. 30904
Weisfeld, Samuel G., 2388 North Lake Dr., Milwaukee 53211
Western, Dennis W., 424 A Beluga, Fort Richardson, Ala. 99505
Wiley, Albert L., Jr., 1300 University Ave., Madison 53706
Williamson, Ladislao M., Southern Wisconsin Colony, Union Grove 53182
Wineinger, David M., P. O. Box 1348, Green Bay 54305
Yount, Loren J., 2266 North Prospect Ave., Milwaukee 53202

DEATHS

Ackerman, Jack S., Milwaukee County, Nov. 9, 1972
Baumgartner, Martin M., nonmember, Nov. 13, 1972
Carlsson, Edward S., La Crosse County, Nov. 14, 1972
Jensen, Frederick G., Winnebago County, Nov. 28, 1972
Weiland, Herbert P., nonmember, Dec. 3, 1972 □

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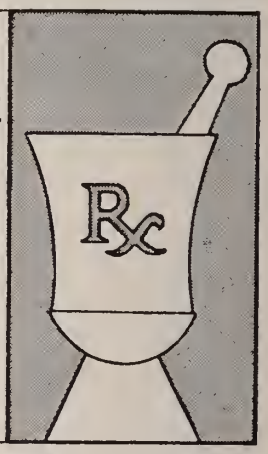

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and Dentistry

Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great of money. I wish we agree on a "grandf clause" approach to p rations that have been for a number of years that have an appar satisfactory track reco

For example, I t some of the antibiotic binations that were t off the market by the performed quite well. thinking particular penicillin - streptom combinations that pat —especially surgical tients—were given in injection. This mad less discomfort for th tient, less demand nurses' time, and f opportunities for do errors. To take su preparation off the m doesn't seem to be medicine, unless actua age showed a great d harm from the injec (rather than the pr use) of the combinatio

The point that shou emphasized is that t are both rational and tional combinations. real question is, who sh determine which is w Obviously, the FDA play a major role in ing this determinatio fact, I don't think it avoid taking the ulti responsibility, but it sh enlist the help of out physicians and expert assessing the evidence in making the ultimat cision.

Maker of Medicine

V. Clarke Wescoe, M.D.
President
Vinthrop Laboratories

f two medications are d effectively to treat a tain condition, and it is own that they are comtible, it clearly is useful l convenient to provide m in one dosage form. would make no sense, in t it would be pedantic, insist they always be escribed separately. To oid the appearance of lantry, the "expert" dees the combination herse it is a fixed dosage m. When the "expert" okes the concept of fixed sage form he obscures fact that single-ingrent pharmaceutical prepations are also fixed sage forms. By a singular nantic exercise he imes a pejorative meaning the term "fixed dose" ly when he uses it with spect to combinations. hat is ignored is the simfact that only in the rest of circumstances es any physician attempt titrate an exact therautic response in his pant. It is quite possible at some aches and pains ll respond to 500 mg. of pirin yet that fact does t militate against the *usl* dose being 650 mg.

The other semantic ploy en called into play is to scribe a combination oduct as rational or irranal.

Take antibiotic mixtures, e source of much of the ticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
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MINOCIN® made the difference in just eight days.*

Clinical Data:
Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat,* 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

Semisynthetic
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MINOCYCLINE HCl
Capsules, 100 mg: 2 *stat,* 1 q 12 h.

Indications: For the treatment of susceptible infections; *e.g., E. coli, D. pneumoniae.* For full list of approved indications consult labeling.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.,* renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

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MEDICAL YELLOW PAGES

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PHYSICIANS EXCHANGE

IMMEDIATE OPENING FOR AN ophthalmologist, family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write S. R. Lee, MD, President, or Russel Peterson, Clinic Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 11tfn

WANTED: GENERAL PRACTITIONER to join 3 young general practitioners in college community in southeastern Wisconsin. Two hospitals with 650 beds. Starting salary with progression to full partnership, vacation, sick leave, and profit-sharing benefits. Contact Dept. 374 in care of the Journal. 7tfn

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

WANTED: INTERNIST, BOARD certified or eligible. Beautiful northeast Wisconsin city of approximately 7000, 8-man mixed group, high standards, attractive working schedule, well equipped office. Extensive recreational facilities locally. Open salary, early partnership. Contact Dept. 387 in care of the Journal. p2–4/73

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living. DISCOVER WATERTOWN, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy-going pace of a residential city.

WE URGENTLY NEED Family Practitioners, Internists, and other specialists to join existing medical staff. An immediate successful practice assured.

Our new Community Health Care Center with its beautiful 110-bed General Hospital, connecting (but separate) 24-Unit Medical–Dental Office Building, and connecting 130-bed Nursing Home, was completed last year.

Watertown, a progressive community, is ideally located equidistant between Milwaukee and Madison in southeastern Wisconsin's lake district. The community has a trade and medical practice area serving 50,000 people. Many new schools, parks, trees, social and recreational facilities. A stable economy.

Excellent rapport with the University of Wisconsin Medical School in Madison and the Medical College of Wisconsin (formerly Marquette University School of Medicine) in Milwaukee. Medical Staff leading and supporting recruitment effort. Write or call E. A. Miller, MD, Chief of Medical Staff, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel. 414/261–4210. 5tfn

MULTISPECIALTY CLINIC IN northeastern Wisconsin is expanding; group seeking allergists, general surgeon, and internist. Ultramodern 500-bed hospital located close to the clinic. Excellent recreational area. Salary first year, corporate member thereafter. Small investment second year into corporation. Young group, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 378 in care of the Journal. 9tfn

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. General Practice
3. Internal Medicine
4. Obstetrics–Gynecology
5. Orthopedics

This is an opportunity to join a 27-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 10–3

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTITIONER to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

THE OSHKOSH CLINIC IS SEEKing associates in the following areas:

1. Allergy
2. General Practice
3. General Surgeon
4. Internal Medicine
5. Dermatology

This is an opportunity to join a 14-man Wisconsin group located in college community of over 60,000 with excellent hospital facilities. Summer and winter recreation unlimited. For further information, contact B. Greenwood, MD, Oshkosh Clinic, Oshkosh, Wis. 54901. p1/tfn/73

WANTED EMERGENCY ROOM physician for daytime coverage, Monday through Friday. Excellent salary, one month paid vacation to join 11-man emergency room corporate group. City of 60,000 with excellent schools, living conditions, and recreation. Contact Community Emergency Services, S.C., P. O. Box 2022, Appleton, Wis. 54911. 1–3/73

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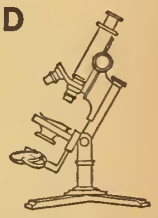

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WANTED: GENERAL PRACTITIONER, preferably of Spanish extraction, with good command of the Spanish language, to associate with 4-man general practitioner group in fast growing city of 40,000. Salary open, 450-bed hospital. Contact by letter or tel: J. L. Nolan, MD, % Waukesha Medical Clinic, S.C., 237 Wisconsin Ave., Waukesha, Wis. 53186. Tel. 414/542–8150 (unlisted number). 12tfn

PHYSICIANS NEEDED: MULTI-specialty group of 23 specialists needs an:

1. Orthopedist
2. Otolaryngologist
3. General Practitioner

Attractive income arrangements, association membership within 1 year, pension, and fringe benefits. Excellent community of 50,000. Contact R. B. Windsor, MD, 1011 N. 8th St., Sheboygan, Wis. 53081. Tel: 414/457–4461. 1/73tfn

WANTED: INTERNIST, GP TO join expanding mixed specialty group in Green Bay. New clinic building and excellent hospital facilities. Contact R. J. Murphy, MD, Deckner Medical Center, 1751 Deckner Ave., Green Bay, Wis. Tel: 414/435–8301. p9/tfn

WILKINSON CLINIC, OCONOMOWOC, Wis., an incorporated group of 11 physicians, with various specialties and general practice represented desires, as associates, general practitioners, internists or pediatricians. Located 25 miles west of Milwaukee, surrounded by lakes, with excellent schools and recreational facilities. 110-bed accredited hospital, with full time pathologist, radiologist, physical therapy services, located 200 yards from 8 year old clinic. Call schedules adjusted with free time and coverage available. Salary open and corporate status after one year. Relocation expenses provided—profit sharing and retirement income plan. For further information please write: Business Manager, Wilkinson Clinic, Oconomowoc, Wis. 53066 or tel: 414/567–4433. 2tfn

RADIATION THERAPY RESIdency—Two positions available in July '73. Approved 3-year program designed to develop competence in clinical oncology, radiation biology, radiation physics in major modern teaching hospital. Direct applications to Director of Radiotherapy, University of Texas Medical Branch, Galveston, Tex. We are an Equal Opportunity Employer. 2–4/73

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Immediate opening for licensed physician to supervise Medical Department and participate in plant occupational health program.

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WANTED—GENERAL OR FAMILY practitioner to join 3-man group. 45-bed hospital in community. 35 miles from St. Paul. Baldwin Clinic, S.C., Baldwin, Wis. 54002. Tel: 715/684–3326. 10–5

INTERNIST OR GP: COUNTY Mental Hospital awakening to its role as comprehensive mental health center needs physician to enlarge and implement the development of a program to meet the medical care aspects of total treatment program. Modern Medicare-certified extended care facility part of complex. New 292-bed mental hospital under construction, scheduled for spring completion, includes abundant space for medical clinic. Staff membership at community general hospital encouraged. Progressive city of 50,000 gateway to Northwoods, excellent schools, outstanding parks, expressway access to Madison (45 minutes), Milwaukee (80 minutes), and Chicago (90 minutes). Excellent opportunity to meet challenge at your own pace with minimum of pressure. Salary $27,000, liberal fringe benefits. Administrator, Rock County Hospital, Box 351, Janesville, Wis. 53545. 2tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

WANTED: GENERAL PRACTItioner, preferably with surgical and obstetrical experience. Ready made practice. No investment. Senior partner retiring. Junior partner desires associate. Ideal midwest college town for family. All educational, recreational, religious, medical and dental facilities readily available in community. Contact Dept. 370 in care of the Journal. 5tfn

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

WANTED: FAMILY PHYSICIAN—eight man mixed group northeast Wisconsin, small city in fertile fishing, hunting, outdoor recreational area, lake and river. Very attractive facilities and call schedule, 84-bed municipal hospital. Open salary, early partnership. Contact Dept. 386 in care of the Journal. p2–4/73

IMMEDIATE OPENING FOR IN ternist or General Practitioner to joi established practice. Brand new clini building and adequate hospital facilitie Good starting salary with partnershi following year. Contact Dept. 363 i care of the Journal. 10tf

PHYSICIAN POSITION AVAILA ble: Student Health Center, Universit of Wisconsin–La Crosse. Excellen physical plant with attached Departmen of Physical Therapy and certified labc ratory. Competitive salary with adequat vacation time and fringe benefits. Equa opportunity employer. Phone, visit o write: Lou R. Schmidt, MD, Studen Health Center, University of Wisconsin La Crosse, La Crosse, Wis. 54601. Tel 608/785–1800, Ext, 226 or 274. 1–3/7

THE PEMBER–NUZUM CLINIC 17-man multi-specialty group, seekin specialists in Internal Medicine. Pediat rics, and Ophthalmology. Excellent re tirement and insurance plans. Write o call collect: P. Richard Sholl, MD, Bo 551, Janesville, Wis. 53545; tel: 1–608/ 752–7811. 4tf

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing health, disability and liability insurance Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

GENERAL PRACTITIONER WITH strong interest or background in industrial medicine needed by eleven-man multispecialty clinic. Full time or part time. Salary negotiable, many fringe benefits Asssociate status possible after one full calendar year. Contact: Administrator, Medical–Surgical Clinic, S. C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215. 2–5/73

E. R. PHYSICIAN TO JOIN GROUP in moderately active emergency room. Milwaukee suburb. $36,000 per year plus fringe benefits. 42-hour week. Equal share of nights and weekends. Inquiries confidential. Contact Dept. 385 in care of the Journal. 2–3/73

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial–agricultural community with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693–3021. This ad endorsed by present doctor. 2–7/73

CAN A YOUNG FAMILY PRACTItioner find: medical, social and economic happiness in "THE NORTH WOODS"? Soap Opera? Not quite! It's all here in Eau Claire, Wis. We're all GPs and we'll be moving in a new office. Don't blame us if you get here too late! Write: G. G. Giffen, MD, Putnam Heights Clinic, P.O. Box 970, Eau Claire, Wis. 54701. 2–6/73

GP WANTED WITH INTEREST IN abdominal surgery to replace member of 4-man group, well equipped clinic, associated with new hospital, in the heart of Kettle Moraine area, 45 minutes from Milwaukee. Salary open, no investment needed. Call collect 414/893–1411, L. J. Steffan, MD. p11–2

WANTED: FAMILY PRACTITIONERS and internists to join 20-man mixed specialty clinic. Teaching opportunities guaranteed. Salary with corporate ownership in two years. William Rock, MD, East Madison Clinic, 1912 Atwood Ave., Madison, Wis. 53704. 6–5

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

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THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine—multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Neurology
2. Orthopedic surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Emergency Room

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 1–3/73

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

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IMMEDIATE OPENING FOR ONE or two general practitioners to join an established small Green Bay group. First year salary, $25,000 or commensurate with training and experience, partnership available. Contact Dept. 367 in care of the Journal. 2tfn

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TWO EMERGENCY ROOM PHYsicians. New group forming to serve 350-bed modern hospital. Seven well equipped emergency rooms. Full specialty back-up and referrals. Opportunity to set up own working conditions. No paper work. Located in a medium-sized midwest city of 60,000. Excellent recreational areas and good living conditions. Contact Sister Mary Gregory, Admin., St. Francis Hospital, La Crosse, Wis. 54601. 10tfn

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THE MARSHFIELD CLINIC IS seeking additional specialists in many areas. This opportunity combines a busy, stimulating referral practice plus an active local practice with an opportunity for family medicine. We provide excellent salary and fringe benefits as well as opportunities for research and teaching. Excellent retirement program and insurance plan. Modern 7-story office building with all diagnostic facilities available. Excellent 400-bed hospital. We are looking for the following specialists:

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2. Otolaryngology
3. Physical Medicine and Rehabilitation
4. Proctology
5. Psychiatrist
6. Radiation Therapy
7. Nuclear Medicine
8. Emergency Room
9. Colon–Rectal Surgeon

For further information, please contact Russell F. Lewis, MD, Medical Director, Marshfield Clinic, Marshfield, Wis. 54449. 12,2,4,6

COMMERCIAL

LARGE PRACTICE AVAILABLE (for sale or rental arrangements) in Ripon, an attractive and comfortable little city. Recently deceased physician's office only three years old—specifically built for two or three doctors. His widow and partner, A. C. Bachus, MD, are very anxious to obtain another physician. Community very anxious, too. Rental arrangements considered reasonable. Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g10tfn

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MEDICAL OFFICE NOW AVAILable. Eleven hundred sq. ft. ground floor, individual controlled heating and air conditioning, paved parking lot. 1925 Washington Ave., Racine, Wis. 53403. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634–6833. 10tfn

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PRACTICES FOR SALE: ATHENS General Practice in modern professional building. Grossing $85,000, netting $60,000. Can be purchased on a lease arrangement with no money down. Wonderful opportunity. MILWAUKEE general family practice. Grossing $90,000 on 4-day week. Much greater potential. Attractive medical building included in this sale. Excellent opportunity for group or individual. MILWAUKEE general family and industrial practice. Ideally located in residential–industrial area. Realistically priced. Call for more details. OTHER EXCELLENT PRACTICES available throughout Wisconsin, Illinois, and Indiana. No fee to buyers. Financing available. Strictly confidential. Free brochure. PROFESSIONAL PRACTICE SALES, 540 Frontage Rd., Northfield, Ill. 60093. Tel. 312/441–6111. 2/73

FOR LEASE. SHEBOYGAN, WIS. Suite, at present occupied by oral surgeon. Available May 1, probably earlier. Other occupants are a physician and dentist. Suitable for any medical or dental specialty. Later purchase of building possible. For details write to Dept. 383 in care of the Journal. 1tfn/73

FOR SALE: BY ILLNESS DISabled physician and surgeon, as a complete unit for clinic or other MDs. Appraised by expert in new and used equipment, at minimum appraisal. All office furniture is of hand finished and rubbed, light walnut. Items: 2 exam and treatment tables, 2 stools, 1 instrument cabinet, 1 treatment stand, 1 exam chair, 1 treatment cabinet with drawers and doors (must be seen to appreciate), 1 sterilizer, 2 head lamps, 1 National procto set, transformer for lights and cautery to accommodate other instruments; 1 Raytheon microtherm, 1 Micro hematocrit, 1 centrifuge, many useful instruments, 1 baby scale, 1 adult scale, 1 Luxo floor light, 1 Miller electro unit, 1 Welch Allen oto & ophthalmoscope, 4 ear syringes—different abilities, 1 General Electric E.C.G. button type, 1 Kidde dry ice, plus sundries useful to the practice of medicine. Below the appraised evaluation, I will take $1500.00 firm. X-ray separate from above articles, 1 General Electric diagnostic table model 39, hand manipulated with all necessary accessories, speed screens, paper holders, some fresh film, hangers, stainless steel tank, etc. $500.00 firm. Call, write, or see: Glenn R. Stauff, MD, 2323 S. Webster Ave., Green Bay, Wis. 54301. Tel: 414/437–3890. 9tfn

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1–2/73

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January 1973 *Blue Book* Update

ADDRESS CHANGE EFFECTIVE MARCH 1: State of Wisconsin, Dept. of Regulation & Licensing, *Division of Nurses*, 201 E. Washington Ave., Madison, WI 53702.

MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Mar. 18–20: Annual Meeting, Wisconsin Association for Perinatal Care, Pioneer Inn, Oshkosh. Info: Perinatal Secretary, Hartford Labs, St. Mary's Hospital Medical Center, 720 S. Brooks St., Madison 53715.

Mar. 24: Annual Banquet, Marquette–MCW Medical Alumni Association, Milwaukee Athletic Club, Milwaukee. Reservations: M–MCW Medical Alumni Assoc., 561 N. 15th St., Milwaukee 53233; tel. 414/272–5450, ext. 250.

Mar. 24: Fifth Annual Southeastern Wisconsin Cancer Conference—"Earlier Cancer Detection," Pfister Hotel, Milwaukee.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Mar. 26–27: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

Mar. 27: Spring Meeting, Wisconsin Surgical Society, Milwaukee.

Mar. 29–31: Midwest Regional Medical Symposium (Exercise and The Heart) and Physical Fitness Clinic, at University of Wisconsin–La Crosse. Info: Dr. Clifton De Voll, Assoc. Dean of HPER, UW—La Crosse, La Crosse 54601.

Apr.: Spring Meeting, North Central Wisconsin Orthopedic Society, Wausau. Info: Thomas O. Miller, MD, President, 630 First St., Wausau 54401.

Apr. 11: Family Practice Conference, Neenah.

Apr. 12: Family Practice Conference, Wausau.

Apr. 18: Family Practice Conference, Eau Claire.

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May: Annual Meeting, Wisconsin Clinic Managers. (Note that this will not be held in conjunction with the Annual Meeting of the State Medical Society as in past years.)

May 4: Spring Conference, Wisconsin Association of Alcohol and Other Drug Abuse, Howard Johnson Motel, Fond du Lac.

May 9: Family Practice Conference, Neenah.

May 10: Family Practice Conference, Wausau.

May 16: Family Practice Conference, Eau Claire.

May 30–31: Symposium on Peptide Synthesis, at The Wisconsin Center on the University of Wisconsin–Madison Campus, Madison. Info: Theo Gerritsen, DSc, Postgraduate Medical Education, WARF Bldg., 610 Walnut St., Madison 53706.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

1973 NEIGHBORING STATES

Mar. 5–10: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, Chicago. 1855 West Taylor St., Chicago, Ill. 60612.

Mar. 17–23: Association of Operating Room Nurses Twentieth Annual Congress, Chicago.

Mar. 25–28: Chicago Medical Society's Midwest Clinical Conference and the Illinois State Medical Society Annual Meeting, Conrad Hilton Hotel, Chicago, Ill.

Mar. 26–29: Continuing education course in Neurotology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, 1855 West Taylor St., Chicago, Ill. 60612.

Apr. 6–7: Seminar on "The Role of the Medical Director in the Long-Term Care Facility," O'Hare Inn, Chicago.

Apr. 16–18: Third Annual Great Lakes Health Congress, McCormick Place-on-the-Lake, Chicago, Ill.

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

June 10–15: 1973—Midwest Institute on Alcoholism, Western Michgian University, Kalamazoo, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Mar. 10–11: Provocative Allergy Course, Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. Info: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609.

Mar. 15–16: 22nd Annual Postgraduate Course in Pediatrics of The University of Texas Medical Branch, Galveston, Tex. Info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Tex Medical Branch, Galveston, Tex. 77550.

Mar. 19–22: Symposium on "Controversial Issues in Pediatric Cardiology, 1973," University of Miami School of Medicine, Division of Pediatric Cardiology, at Sonesta Beach Hotel, Key Biscayne, Fla.

Mar. 19–22: Annual Meeting, New Orleans Graduate Medical Assembly, at Fairmont Roosevelt Hotel, New Orleans, La.

Mar. 21–22: Course in "Hodgkin's Disease, Leukemia, and Lymphoma," Cleveland Clinic Educational Foundation, Ohio.

Mar. 21–24: Postgraduate Seminar on "Emergency Medicine" Florida Chapter, American College of Emergency Physicians, at Playboy Plaza Hotel, Miami Beach, Fla.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: First Annual Four-Day Spring Meeting, American College of Surgeons, Americana and Hilton Hotels, New York.

Apr. 11–13: Annual Meeting and National Conference, National Society for the Prevention of Blindness, Inc., at Hotel Roosevelt, New York City.

Apr. 16–19: American Industrial Health Conference, Currigan Hall, Denver, Colo. Info: Industrial Health Conference, 150 North Wacker Drive, Chicago, Ill. 60606.

Apr. 26–28: Fourth National Congress on Medical Ethics, Washington Hilton, Washington, D.C.

May 4–5: Annual Conference, British Columbia Oto-Ophthalmological Society, Hotel Vancouver, Vancouver, B.C.

May 20–25: Hospital Medical Staff Conference, Sun Valley, Idaho. Info: Northwest Hospitals Education and Research Alliance, % Oregon Association of Hospitals, 220 S.W. Morrison St., Portland, Ore. 97204; tel. 503/228–5608.

May 20–26: American Gastroenterological Association postgraduate course, *Cirrhosis and Portal Hypertension* as part of Digestive Disease Week. Americana Hotel, New York. Info: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N. J. 08086.

May 29–31: Postgraduate seminar *Master Interpretation of Clinical Electrophysiology* sponsored by University of Miami School of Medicine and Council on Clinical Cardiology of the American Heart Association. Contemporary Hotel at Disney World, Lake Buena Vista, Fla. Info: Dr. Louis Lemberg, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

June 14: Eighth Annual Continuation Course on "Clinical Electroencephalography," Statler–Hilton Hotel, Boston, Mass. Info: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55901.

June 15–16: Annual Meeting, American Electroencephalographic Society, Statler–Hilton Hotel, Boston, Mass. Info: Mrs. Margaret H. Henry, Exec. Secy., American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

1973 AMA

Mar. 7–10: Quality of Life Congress, Palmer House, Chicago.

Mar. 22–25: Medicolegal Symposium, Hilton International Hotel, Las Vegas.

Mar. 29–30: 26th National Conference on Rural Health, Statler Hilton Hotel, Dallas.

Apr. 6–7: 19th Annual Conference of State Mental Health Representatives, Drake Hotel, Chicago.

Apr. 13–14: 7th National Congress on the Socio-Economics of Health Care, Marriott Motor Hotel, Chicago.

Apr. 26–28: 4th National Congress on Medical Ethics, Washington–Hilton Hotel, Washington, D.C.

* * *

The Role of the Medical Director in the Long-Term Care Facility. Sponsored by Committee on Aging, Council on Medical Service, American Medical Association, with the support of U. S. Department of Health, Education, and Welfare, Health Services and Mental Health Administration, Community Health Service. To be held for the states in HEW Region V, including Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. April 6–7 at O'Hare Inn, Chicago. High priority of the seminar is to stimulate interest, knowledge, and commitment in this field, with the possibility of establishing more permanent programing on state and local levels in future years. Individual physicians and administrators as well as organized groups who are involved or interested in long-term care are encouraged to attend. Acceptable for 14 elective hours by the American Academy of Family Physicians and 14 credit hours in category No. 2 for AMA Physician's Recognition Award. No registration fee required. Further info: Division of Medical Practice, AMA, 535 North Dearborn St., Chicago, Ill. 60610; tel. 312/527–1500.

Midwest Clinical Conference of the Chicago Medical Society and the Annual Meeting of the Illinois State Medical Society will be held March 25–28 at the Conrad Hilton Hotel in Chicago. Programmed with the cooperation of 30 specialty societies. Full-day trauma session. Fully-accredited instruction courses. Continuous medical film program. Scientific and technical exhibits. Special events and functions. Further info: Chicago Medical Society, 310 South Michigan Ave., Suite 1616, Chicago, Ill. 60604. (See ad elsewhere in this issue.)

Annual banquet of the Marquette–MCW Medical Alumni Association will be held Saturday, March 24, at the Milwaukee Athletic Club. Social hour at 6:00 pm, and dinner at 8:00 pm. Dinner will include entertainment and dancing, and presentation of alumnus of year award.

Those alumni who graduated in 1923, 1927, 1933, 1937, 1943, 1947, 1953, 1957, 1963 and 1967 will have special reunion get-togethers. Special recognition will be given to the class of 1948, celebrating its silver jubilee.

Reservations: Marquette–MCW Medical Alumni Association, 561 N. 15th St., Milwaukee 53233; (tel. 414/272–5450, ext. 250).

Midwest Regional Medical Symposium (Exercise and The Heart) and Physical Fitness Clinic will be held at the University of Wisconsin–La Crosse on March 29–31. It will feature one day devoted to the medical aspects of physical fitness and two days devoted to the role of the school in physical fitness, including sessions from the view of the handicapped program, the elementary program, and the secondary program. Clinic fee is $3.00 per person. Further info: Dr. Clifton De Voll, Associate Dean of HPER, University of Wisconsin–La Crosse, La Crosse 54601.

New Orleans Graduate Medical Assembly. Dr. William M. Lukash, White House Physician, and Head, Gastroenterology Clinic, U.S. Naval Hospital, will be one of the many distinguished speakers from throughout the country participating at the 36th annual meeting of The New Orleans Graduate Medical Assembly this year. Meeting dates are March 19–22, and headquarters will be again at the Fairmont Roosevelt Hotel. Dr. Lukash will speak on "Observations of Chinese Medicine," a report on his visit to China with President Nixon. Other well known physicians will report on medical advancements in their various specialties.

A continuous showing of medical motion pictures, luncheons for specialty groups, a clinicopathologic conference, technical exhibits, and planned entertainment for wives will add interest to the three and a half day meeting. This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by the American Academy of Family Physicians. Further info: The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La. 70112. (Also see advertisement elsewhere in this issue.)

Fifth Annual Southeastern Wisconsin Cancer Conference. Pfister Hotel, Milwaukee, Saturday morning, March 24. Presiding: James E. Youker, MD, co-chairman with Joseph F. Kuzma, MD.

8:15–9:15 am: Registration, Imperial Ballroom. 9:15 am: Wm. M. Christopherson, MD, University of Louisville, Ky.—"The Long Term Effects of Uterine Cancer Control."

9:45 am: Gerald D. Dodd, Jr., MD, University of Texas M. D. Anderson Hospital and Tumor Institute—"Thermography and Mammography As Diagnostic Aids."

10:30 am: S. B. Pessin, MD, Memorial Lecture by Robert V. P. Hutter, MD, College of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark—"Early and Marginal Breast Cancer."

11:00 am: Jack W. Cole, MD, Yale University School of Medicine, New Haven, Conn.—"Studies on the Morphogenesis of Colonic Tumors."

11:30 am: Arthur I. Holleb, MD, American Cancer Society, New York City—"Breast Cancer Detection Demonstration Projects in the U.S."

12:00 pm: Panel discussion with Joseph F. Kuzma, MD, moderator, and the above speakers.

1:00 pm: Luncheon and discussion. Luncheon tickets $5/person. No fee for

Members of the State Medical Society of Wisconsin are invited to attend the many interesting scientific presentations and exhibits scheduled for the

1973 ANNUAL MEETING
of the
Wisconsin Dental Association

Meetings will be held Monday, May 7, through Wednesday, May 9, at the Milwaukee Auditorium. A physician's 1973 membership card will permit him to register. To register, use the Kilbourn Avenue entrance between the Auditorium and Arena.

conference. Reservations to: Southeastern Wisconsin Cancer Conference, % St. Joseph's Hospital, 5000 W. Chambers St., Milwaukee, Wis. 53210. Four hours of elective credit by Academy of Family Physicians.

American College of Surgeons. Marking a major change in its long-range educational program, the American College of Surgeons will sponsor its first annual four-day Spring meeting in New York on Sunday, April 1, through Wednesday, April 4, at the Americana and Hilton Hotels.

In a sense, the New York meeting will be a four-day workshop devoid of business and social activities. It will provide eight postgraduate courses planned by nearly 150 outstanding surgeons working closely with the Surgical Education and Self-Assessment Program (SESAP) of the College, which now has been subscribed to by more than 12,000 surgeons, including Fellows (members), non-Fellows and residents.

The essential feature of SESAP is a voluntary, self-administered challenge assessment, offering a mechanism whereby participants may accurately measure how well they have kept up with surgical progress, define for themselves alone the areas in which they are deficient, and follow a continuing education program matching their individual needs.

The nine-hour postgraduate courses will be supplemented by two days of symposia, panels, lectures and motion pictures.

"Purpose of this new annual meeting is to provide a well-rounded educational program which does not duplicate the Clinical Congress program, choosing courses based on the College's interpretation of need," said Edwin W. Gerrish, MD, FACS, assistant director in charge of the College's scientific programs. "Outstanding leaders in surgery, plus organizers of the SESAP program, plus planners of the Clinical Congress have collaborated in organizing this meeting, which replaces our previous schedule of three smaller Sectional Meetings."

Fees for postgraduate courses, approved by the American Medical Association for credit as continuing education courses, is $35 for all registrants, manual included. Registration for the meeting is a prerequisite for registering in the postgraduate courses.

Registration for the meeting will be free of charge to Fellows of the College whose dues are paid to date, members of the ACS candidate group, and surgical residents. Non-Fellows, applicants for Fellowship and Fellows whose dues have not been paid, pay $50. Non-Fellows in the Federal Services (full-time) pay $30.

Registered nurses and interns who present proper credentials may register free for the general sessions and exhibits, but are not eligible for the postgraduate courses.

Housing and registration forms are available from the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. □

CONTRIBUTIONS—CES FOUNDATION

December 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1972:

Unrestricted

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Guest Speakers Fund

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BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

Practical Automation For The Clinical Laboratory. By Wilma L. White, Marilyn M. Erickson, Sue C. Stevens. The C. V. Mosby Co., St. Louis, Mo. 1972. 591 pages. Price: $22.50

Director of Institutions for Mentally Disordered Offenders. By National Institute of Mental Health. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 1972. 24 pages. Price: $.25

Common Problems in Office Practice. By Robert B. Taylor, MD. Medical Department, Harper & Row, Publishers, Inc., 2350 Virginia Ave., Hagerstown, Md. 21740. 1972. 402 pages. Price: $9.95

Female Sex Anomalies. By Cary M. Dougherty, MD and Rowena Spencer, MD. Medical Department, Harper & Row, Publishers, Inc., 2350 Virginia Ave., Hagerstown, Md. 21740. 1972. 288 pages. Price: $12.75

Handbook of Medical Treatment. Edited by Milton J. Chatton, MD. 1972. Lange Medical Publications, Los Altos, Calif. 94022. 648 pages. Price: $6.50

Educating Personnel for the Allied Health Professions and Services. By Edmund J. McTernan and Robert O. Hawkins, Jr. The C. V. Mosby Co., St. Louis, Mo. 1972. 225 pages. Price: $10.50

Communicable and Infectious Diseases. Edited by Franklin H. Top, Sr., MD and Paul F. Wehrle, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 803 pages. Price: $35.00

Laboratory Medicine: Hematology. By John B. Miale, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 1318 pages. Price: $27.50

Blood Diseases in Infancy and Childhood. By Carl H. Smith, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 874 pages. Price: $29.75

Symposium on Myelomeningocele. By American Academy of Orthopaedic Surgeons. Hartford, Conn., Nov. 1970. The C. V. Mosby Co., St. Louis, Mo. 1972. 317 pages. Price: $24.00

Immunology Immunopathology and Immunity. By Stewart Sell, MD. Harper & Row, Publishers, Inc., Medical Dept., 2350 Virginia Ave., Hagerstown, Md. 21740. 1972. 277 pages. Price: $12.95

How to Divide Medical Words. By Richard V. Lee, MD and Doris J. Hofer. Southern Illinois University Press, Carbondale and Edwardsville, P. O. Box 3697, Carbondale, Ill. 1972. 229 pages. Price: $4.50

Manual for Pharmacy Technicians. By Sister J. M. Durgin, Charles O. Ward and Zachary I. Hanan. The C. V. Mosby Co., St. Louis, Mo. 1972. 117 pages. Price: $5.50

Hereditary Retinal and Choroidal Diseases. By Alex E. Krill, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 354 pages. Price: $19.75

Vascular Surgery, Volume I: Peripheral Arterial Diseases. By John J. Cranley, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 282 pages. Price: $19.95

Encyclopaedia of Occupational Health and Safety. McGraw–Hill Book Company, 1221 Avenue of the Americas, New York, N. Y. 10020. 1972. 1621 pages. Two volumes. Price: $49.50

Diseases of the Vulva. By Nikolas A. Janovski, MD and Charles Douglas, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 125 pages. Price: $17.50

Pathogenic Mycoplasmas. Ciba Foundation Symposium. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corp., Summit, N.J. 07901. 1972. American Elsevier Publishing Co., Inc., 52 Vanderbilt Ave., New York, N. Y. 10017. 404 pages.

Radiologic Examination of the Urinary Tract. By Howard M. Pollack, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 164 pages. Price: $8.50

Synopsis of Gross Anatomy, 2nd edition. By John B. Christensen, PhD, and Ira R. Telford, PhD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 304 pages. Price: $10.95

Essentials of Roentgen Interpretation, 3rd edition. By Lester W. Paul, MD and John H. Juhl, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 1,144 pages. Price: $35.00

Current Concepts in Radiology. Edited by E. James Potchen, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 346 pages. Price: $24.75

Renal Disease in Childhood. By John A. James. The C. V. Mosby Co., St. Louis, Mo. 1972. 360 pages. Price: $23.50

Risks in the Practice of Modern Obstetrics. Edited by Silvio Aladjem, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 304 pages. Price: $29.50

Heritable Disorders of Connective Tissue, 4th Edition. By Victor A. McKusick, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 878 pages. Price: $32.50

Ontogeny of Acquired Immunity. Ciba Foundation Symposium. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corp., Summit, N. J. 07901. 1972. American Elsevier Publishing Co., Inc., 52 Vanderbilt Ave., New York, N. Y. 10017. 283 pages.

BOOK REVIEWS

Cognitive and Mental Development in the First Five Years of Life

National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015. Nov. 1970. Superintend- of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 111 pages. Price: 55¢.

Drs. Lichtenberg and Norton have condensed an enormous amount of research data and observation in 111 pages of their report. They have done a masterful job of integrating and correlating these findings combined with some of their own comments on the significance of data reported by various authors in the recent literature on cognitive development in young children. A word of warning is in order to alert the prospective reader, this report is not easy to grasp. The authors attempt to cover so many different investigators' findings that it requires diligent, careful reading. The effort is worth it, however, because of the valued orientation of the newer concepts of cognitive development that was pioneered by Piaget.

Inherent in the report is the application of their findings to culturally and socioeconomically deprived children. Section III entitled, "Some Issues in Programs Directed Toward Infants and Young Children," is especially indicative of one of the motivations for their work. This last section is especially valuable with the upsurge in children's programs such as "Headstart" where effort is be-

CES FOUNDATION CONTRIBUTIONS . . .

Aesculapian Society

Mrs. Albert J. Baumann, Mrs. Robert G. Cullen, Mrs. Robert E. Johnston, Mrs. Bernard S. Schaeffer, Mrs. C. R. Lyons, Mrs. Ralph E. Tomkiewicz, Mrs. Kenneth M. Smigielski, and Mrs. William C. Janssen ---------- Contributions

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Mrs. Cyrus G. Reznichek ---------- Memorials: Edward Shipek, John D. Albright, Mrs. Ringlemann

Mr. and Mrs. Thomas J. Thorsen -- Memorial: C. G. Reznichek, MD □

ing put into reversing the hypothetical "damage" done to the child through cultural deprivation. The rise in learning disorders in children is one of the unsolved challenges confronting educators, parents, child psychiatrists and the nation as a whole since the success of our society depends on education and the capacity for learning for everyone of its citizens. The research data on the growth changes in cognitive development show that changes are not as easily accomplished nor are the changes as permanent as originally thought. In some ways this may have been anticipated by failure to recognize the impact of the total family on learning. Those research programs that involved the parents seem to hold the most promise.

Without question this report serves a valuable service in summarizing a valuable body of research available in no other easily accessible way.—HAROLD F. BORENZ, MD

Report on the XYY Chromosomal Abnormality

National Institute of Mental Health, Center for Studies of Crime and Delinquency. 5454 Wisconsin Ave., Chevy Chase, Md. 20015. Oct. 1970, U. S. Department of Health, Education, and Welfare. 55 pages.

This 55 page monograph is based in large measure on discussions held during a two-day conference on the XYY Chromosomal Abnormality sponsored by the Center for Studies of Crime and Delinquency, NIMH, in June, 1969. The importance and timeliness of the report stems from the wide publicity that has been given in the news media to civil criminal trials in which the XYY chromosome constitution was put forward by the defense as evidence against criminal responsibility.

Studies conducted so far have mostly been on limited and often selected groups of inmates of penal and mental institutions. In spite of this selection, the conferees arrived at a formal consensus regarding criminal responsibility, that "the demonstration of the XYY Karyotype in an individual does not in our present state of knowledge, permit any definite conclusions to be drawn about the presence of mental disease or mental defect in that individual. A great deal of further scientific evidence is needed."

It is further pointed out that modern genetic thinking in no way views genetic or other hereditary influences in an absolute or fatalistic manner. Very complex and continued interactions among hereditary, social and environmental factors determine or influence human behavior. No direct cause and effect relationship of aberrant or deviant behaviors with the XYY chromosome constitution is seen to exist, but the XYY genotype can certainly be a factor contributing in some measure to a particular pattern of behavior. At any rate, the treatment needs should be indicated by the particular pattern of problem behaviors manifested and not by the chromosomal abnormality itself; i.e., immediate efforts would need to be directed at the specific behavior problems themselves and not at the chromosome.

The importance of this brief monograph lies principally in its clear outline of the multiple problem areas involved, pointing to major gaps in knowledge and needs for additional research, and the collection of relevant bibliographies.—CARL H. FELLNER, MD

Shands' Handbook of Orthopaedic Surgery

By R. Beverly Raney, Sr., & H. Robert Brashear, Jr. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 543 pages. Price: $15.50.

Publishing the eighth edition of this book, now authored by a former resident of the original author, is testimony to its acceptance over the years. This edition is improved with new illustrations and updated material.

While it is especially designed as an introduction of orthopaedics to medical students, this book is a comprehensive text and goes into sufficient detail to provide the fundamentals of this subspecialty, without going into details of operative procedures.

The illustrations are very good as to content and clarity of reproduction and are numerous. Type is clean and the format is uncluttered, aiding reading ease. The general organization of contents is logical and inclusive, with a good index and an up-to-date bibliography conveniently located as an appendix.

In general reference to treatment is limited to that which has stood the test of time and of alternatives generally accepted as good practice. Some of the newer, or semi-experimental, procedures are not mentioned, and properly so, to attend the purpose of this excellent book. It is recommended to medical students or practitioners wishing to have a well organized over-review of fundamental orthopaedic surgery.—EUGENE J. NORDBY, MD

Handbook of Poisoning

By Robert H. Dreisbach. Lange Medical Publications, Los Altos, California. Seventh Edition. 1971. 515 pages. Price: $6.00.

This book is best suited for the rapid retrieval of information about *specific* poisons. The information is, of course, sketchy. What is most serious, however, is that the approach to an emergency situation in which the poison is *unknown* is inadequate. There are, in addition, errors, (give charcoal, then ipecac . . . which would be neutralized by the charcoal!). The tiny print and inadequate emphasis make the "handbook" nature of the treatise less convenient than implied. It would be more appealing to have a "show and tell" approach to this subject, an area of medicine inadequately appreciated by many students and physicians.—THEODORE L. GOODFRIEND, MD □

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trends

The Wisconsin Regional Medical Program, Inc.

FEBRUARY, 1973

Wisconsin RMP Receives $2,383,230 Award, Health Program In Jeopardy After June 30, 1973

ll-Burton and MP's Expected To e Hit Hardest

Regional Medical Programs Serv- . Washington, D. C., has notified Wisconsin RMP that it has n awarded $2,383,230 through ne 30, 1973. The award includes ntinuing support for the Emer- ncy Medical Service Project which s funded out of 1972 Federal fis- funds and which will be avail- e for the completion of the two- ur project. The remainder of the nds are for support of the Wiscon- RMP until June 30, 1973. The ard was authorized in accordance h the budget request submitted the Wisconsin RMP last year.

Following the announcement re- ding the award, the Wisconsin MP received a communication m RMPS requesting a plan for asing out the program after June This action was taken as the re- t of President Nixon's budget ssage to Congress which did not ovide for continuing support for gional Medical Programs along h many other Federal health pro- ms, including Hill-Burton.

In announcing the award, Dr. rschboeck noted that many health ograms in the Department of alth, Education, and Welfare EW) are in jeopardy.

"President Nixon is expected to Congress to cut back health pro- ms and, in some cases, eliminate em completely," Dr. Hirschboeck said. "Hill-Burton and Regional Medical Programs have an uncertain future. Comprehensive Health Planning is expected to be curtailed 10 percent, while emergency medical service programs are expected to receive the same budget they received in fiscal '73 — $115 million."

The new Secretary of HEW, Caspar W. Weinberger, was instrumental in shaping the new budget since this was done while he was in his previous position as head of the Office of Management and Budget.

"It is difficult to say exactly what effect all of this will have on our projects after July 1, 1973," Dr. Hirschboeck said. "At this time, however, it appears that unless Congress appropriates funds at the same level as fiscal '73 and authorizes continuation of the program, our finances will be cut drastically, and the continuation of Wisconsin RMP will be in jeopardy."

The Wisconsin RMP had several projects planned to begin or continue in 1973, including a cancer treatment review program, quality medical care assurance project, and peer review project enabling physicians to establish criteria for use in self evaluation as well as evaluation by county medical societies.

Some projects that were recently given short-term organizational

(Continued on Page 2)

Mrs. Robert Dineen Named Chairman of Advisory Group

T. A. Duckworth, Wisconsin RMP and Senior Vice President, Employers Insurance of Wausau, announced the appointment of Mrs. Robert E. Dineen, M.A., J.D., Chairman of the Wisconsin RMP Regional Advisory Group.

Duckworth also announced the appointment of Dr. John Kimball Scott as Vice Chairman.

The objectives of the Regional Advisory Group are to:

- Establish the goals of the Wisconsin RMP
- Set program priorities for operational and staff activities
- Examine project requests and take action for support or non-support
- Oversee budget policy and major budget allocations
- Evaluate organizational structure and significant Wisconsin RMP activities.

Newly appointed members to the Advisory Group were: John M. Bell, M.D., Marinette; David L. Besaw, Psychology Technician, Indian Health Service, Rhinelander; Robert R. Cadmus, M.D., Executive Director, Medical Center of Southeastern Wisconsin, Milwaukee; Mrs. Elaine F. Ellibee, R.N., Consultant in Nursing Practice, Board of Nursing and Division of Nurses, Madison.

(Continued on Page 3)

Von Ehren, Blockstein Appointed To Head Committees

Von Ehren Chairs Wisconsin RMP Steering Committee

Warren R. Von Ehren, Executive Director, Wisconsin Hospital Association, has been reappointed Chairman of the Wisconsin RMP Steering Committee.

The purpose of the Steering Committee is to recommend to the Regional Advisory Group goals and objectives for the Wisconsin RMP, and to recommend ways to implement and identify areas of need for RMP program development.

Other Committee members confirmed by the Regional Advisory Group are: George H. Handy, M.D., State Health Officer, Division of Health, Department of Health and Social Services, Madison; Glenn Hoberg, D.O., River Falls; Russell F. Lewis, M.D., Marshfield Clinic, Marshfield; John W. Maxwell, Jr., M.D., Milwaukee; Gerald Nadler, Ph.D., Professor of Industrial Engineering, University of Wisconsin, Madison; Donald M. Willson, M.D., Milwaukee; Rodney Lee Young, J.D., Rusk County Courthouse, Ladysmith; and Marie J. Zimmer, R.N., Director of Nursing Service, University Hospitals, Madison.

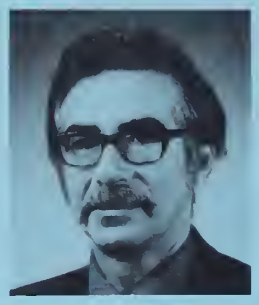
Kirsch Leaves Wis. RMP, Joins Marshfield Clinic

Dr. John S. Hirschboeck, Wisconsin RMP, has announced the resignation of Peter A. Kirsch as Director of Public Information. Kirsch has been named Manager of Communications for the Marshfield Clinic, Marshfield, Wisconsin.

Dr. Hirschboeck has no immediate plans to fill the position. He said, however, that, in agreement with the Marshfield Clinic, Kirsch will continue to assist the Wisconsin RMP with its public information program for the next several months.

Kirsch has been with the Wisconsin RMP since 1968.

Warren R. Von Ehren



William L. Blockstein

(Continued from Page 1)

RMP In Jeopardy . . .

funds will most likely feel the immediate effects of the expected federal cutback.

"All of the projects were given developmental funds to organize themselves, giving them a head start when a long-term grant became available," Dr. Hirschboeck said. "Now, unless these are able to secure funds from private sources, their projects will be lost."

In order to head off the possible cutback which, in some cases, has been called a complete "elimination" of such programs as RMP's, all 56 RMP coordinators have taken an optimistic viewpoint of the situation.

"We feel that too few people really understand the nature and need of RMP's," Dr. Hirschboeck said. "By showing what we have accomplished in the past and how we are planning today to provide an improved health care delivery system for tomorrow at the regional level I am confident we can come out of this with Congressional support and continued funding."

Review and Evaluation Committee Post To Blockstein

William L. Blockstein, Ph.D., Di rector of the Health Sciences Uni in the Division of Professional an Human Development, University o Wisconsin-Extension, has bee named Chairman of the Revie and Evaluation Committee of th Wisconsin RMP.

The Review and Evaluatio Committee is responsible for th technical excellence of all RM Projects. It also has the respons bility for making recommendation regarding their continuance to th Regional Advisory Group. Th Committee is also responsible fo providing background material an recommendations for new program and projects under consideratio by the advisory group.

Also appointed to the Committe were: John R. Beaton,-Ph.D., Dea of the Colleges, The University Wisconsin-Green Bay, Green Ba Betty M. Callow, R.N., Ass't V Occupational Health Nursing Ser ices, Employers Insurance of Wa sau, Wausau; John R. Gesicki, E gar; Harold C. Guntner, Executi Director, Hospital Council of Grea er Milwaukee Area, Milwauke Edwin R. Larkin, M.D., Assista State Health Officer, Division Health, Department of Health a Social Services, Madison; M Warren Lensmire, Stevens Poi Paul F. Markgren, Executive Dire tor, Northwest Areawide Comp hensive Health Planning Organiz tion, Inc., Hayward; Mrs. Margar Mirenda, M.S., O.T.R., Mount Ma College, Milwaukee; Eugene M Molitor, Executive Director, We ern Wisconsin Health Planning O ganization, Inc., La Crosse; John Petersen, M.D., Director of Medic Services, Milwaukee County I stitutions and Departments, M waukee; P. Richard Sholl, M.I Janesville.

It's Worth Saving

By
JOHN S. HIRSCHBOECK, M.D
Program Coordinator

Most of us who were at the White House when the te President Lyndon B. Johnson signed Public Law)-239 which established the Regional Medical Pro- ams were stimulated to go forth and introduce what romised to be a unique plan and program which would ing the latest benefits of medical science as quickly as ossible to all our people. Hospitals, physicians, and ealth professionals of all kinds would join forces with ach other to improve the diagnosis and treatment for atients afflicted with the "killer diseases" and thereby nprove the health care delivery system and the quality f the services provided.

A program which set out to improve what is so often alled a "non system" was bound to have problems in ulling disparate institutions and professional groups ogether into more effective cooperation to deal with ajor medical problems facing society.

Now that the RMP's have come of age, it is paradox- al that the Nixon Administration plans to phase out e very programs which it needs to assist in the expan- ion of quality assurance procedures now required by e government involvement in the health care delivery ystem. Fortunately many members of Congress in both arties see the need to continue the functions now performed by the Regional Medical Programs if greater efficiencies are to be achieved. The expiration of enabling legislation for the Regional Medical Programs and sixteen other HEW health programs in June of 1973 provides a unique opportunity for Congress to provide legislation to continue those effective and necessary programs and eliminate those which are no longer relevant. I predict that we will find the RMP mission preserved as a key element in the revised legislation. The RMP's throughout the country have mobilized the providers of health care in a way which adds a new dimension to effective collaboration and communication into the system, a dimension which can continue to exert immeasurable effects for good.

ntinued from Page 1)

Regional Advisory Group Now At 49 Members

Other members presently serving n the Advisory Group are: Fred J. nsfield, M.D., Professor, Division f Clinical Oncology, Madison; ohn A. Arkins, M.D., Medical ollege of Wisconsin, Milwaukee; oger A. Baird, Secretary, Kimber- -Clark Corporation, Neenah; J. . Banks, Executive Director, West entral Wisconsin Community Ac- on Agency, Glenwood City; Wil- am L. Blockstein, Ph.D., Profes- or and Director, Health Sciences Unit, University of Wisconsin-Ex- ension, Madison; Robert E. Cal- an, M.D., Milwaukee; Kenneth D. Clark, Wisconsin, AFL-CIO, Mil- vaukee; Perry P. Cohn, D.D.S., Milwaukee; George E. Collentine, r., M.D., The Northpoint Medical Group, Ltd., Milwaukee;

Dean A. Emanuel, M.D., Marsh- ield Clinic, Marshfield; Gabriel . Ferrazzano, M.D., Commis- ioner of Health, City of Racine, Racine; Paul F. Fleer, M.Ed., Ex- ecutive Director, Health Planning Council, Inc., Madison; W. W. Grover, M.D., Bonduel Clinic, Bon- luel; George H. Handy, M.D., State Health Officer, Division of Health, Department of Health and Social Services, Madison; Vincent F. Otis, Acting Director, Bureau of Comprehensive Health Planning, Division of Health, Department of Health and Social Services, Madison; Glenn Hoberg, D.O., River Falls; Richard A. Holmes, M.D., Director of Nuclear Medicine, Medical College of Wisconsin, Milwaukee; Sister M. Jeanne, F.A.C.H.A., President, St. Joseph's Hospital, Milwaukee; Mrs. Warren Lensmire, Stevens Point;

John E. Linster, Senior Vice President, Government Affairs, Employers Insurance of Wausau, Wausau; Joseph M. Lubitz, M.D., Oconomowoc; Paul B. Mason, M.D., The Sheboygan Clinic, Sheboygan; Thomas C. Meyer, M.B., B.Ch., M.R.C.P. (Edin.), Associate Dean for Postgraduate Medical Education, Madison; Dale V. Moen, M.D., The Shell Lake Clinic, Ltd., Shell Lake; E. J. Nordby, M.D., Bone and Joint Surgery Associates, Inc., Madison; John R. Petersen, M.D., Director of Medical Services, Milwaukee County Institutions and Departments, Milwaukee; Harold C. Ristow, President, Western Wisconsin Health Planning Organization, Inc., La Crosse;

David A. Scott, Sr., Executive Director, Cream City Neighborhood Health Centers, Inc., Milwaukee; George R. Seidenstricker, Associate Administrator, St. Alphonsus Hospital, Port Washington; Alice M. Semrad, M.T. (ASCP), Director, Medical Technology Curriculum, Medical College of Wisconsin, Milwaukee; Bernard J. Shannon, O.D., Mauston; P. Richard Sholl, M.D., Janesville, Bernard Solochek, Barkin, Herman and Associates, Milwaukee;

Robert H. Steuck, Ed.D., Assistant to the Chancellor, The University of Wisconsin-La Crosse, La Crosse; Mrs. F. Jackson Stoddard, Milwaukee; Joseph T. Stuart, Superior; Warren R. Von Ehren, Executive Director, Wisconsin Hospital Association, Madison; John H. Wishart, M.D., Eau Claire; and Marie J. Zimmer, R.N., Director of Nursing Service, University Hospitals, Madison.

Allied Health Council Members Announced

Named to the Council for Allied Health Professions were:

Alice M. Semrad, M.T. (ASCP)
Chairman
Director, Medical Technology Curriculum
Medical College of Wisconsin
Milwaukee

Mrs. Janet L. Christian, R.D.
Representative, Wisconsin Dietetic Association
Madison

Dennis Dziczkowski, R.Ph.
Representative, Wisconsin Pharmaceutical Association
Hales Corners

Raymond L. Guenveur, O.D.
Representative, American Optometric Association
Mount Horeb

Kevin P. Kortsch, D.P.M.
Representative, Wisconsin State Podiatry Society
Wauwatosa

Janet C. Lemke, P.T.
Representative, American Physical Therapy Association, Wisconsin Chapter
McFarland

Mrs. Anne McNamara, R.R.A.
Representative, Wisconsin Medical Record Association
Milwaukee

Mrs. Margaret Mirenda, O.T.R.
Chairman, Department of Occupational Therapy
Mount Mary College
Milwaukee

David A. Sazama
Representative, American Association for Respiratory Therapy
Cudahy

Bernardine Serwa, R.T.
Representative, Wisconsin Society of Radiological Technologists
Milwaukee

The objectives of the Council are to:

1. Provide a forum for discussions of problems in health care delivery and professional education as they apply to the allied health professions and to health care in general.
2. Recommend to the Regional Advisory Group appropriate participation of the allied health professions in WRMP programs and projects.
3. Stimulate the development of continuing education activities for the allied health professions as they relate to WRMP goals.
4. Foster programs which improve interprofessional educational activities and interprofessional collaboration.

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Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
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PRESIDENT'S PAGE

Twilight

THESE ARE THE WANING DAYS for me as President of our State Medical Society. I would indeed be made of stone if I did not reflect on the year just past. It was a year of great interest in the problems affecting the health care here in Wisconsin. Throughout our great state physician members of our Society showed a stirring, an interest, and above all a participation in county and state meetings.

The many meetings of the Society committees and commissions were of never ending interest. It will always be a source of pride to know that busy physicians from the far flung corners of our state are willing and ready to work within the Society committees in promoting the health of our citizens.

The cult of chiropractic was laid bare in a devastating, remarkable committee report to the Health Task Force which in turn unanimously accepted this committee's recommendations. The citizens of Wisconsin can now await the Governor's decision on what to do with this document. His track record on chiropractic will make it difficult.

The House of Delegates will always be the spokesman for the State Medical Society on matters of major policy. Throughout the year, however, the Council and Officers must accept the final authority and direction for the operation of this Society. This line of authority must not be tampered with or diluted. Our Secretary and chief executive officer must continue to serve and be responsible, with full authority, to the Council for seeing that Society policies are effectively carried out. Good tight lines of communication between the Council and Society members will always deserve top priority.

Our Society is twice blessed in having an able, loyal, and highly motivated corps of people working at Society headquarters and throughout the state. To all who have so ably assisted me this year, my sincere thank you.

Grave legislative proposals stemming from the Task Force on Health stand before us. The eager hand of the politician would enfold us in a state-appointed commission. The Washington, D.C. AMPAC meeting served as a jarring reminder that Wisconsin lags badly in political action and the adequate financing of WISPAC. I do hope that a strong plan of action will be developed at the Annual Meeting.

It has been a very great honor serving as your President. I love the medical profession for all it is and all it stands for with a fierce and undying love. We physicians all belong to a unique and honored profession, who in our daily work are privileged in a most intimate way of extending help to our suffering fellow man. This we shall never surrender.

Robert F. Purtell MD

ROBERT F. PURTELL, MD

Editorials

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Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Drugs and Doctors

No one really believes that physicians are responsible for drug abuse in our society today, and yet we are being inexorably drawn into the net of complex factors which constitute the public thinking about drugs and drug abuse. Curiously there seems to be very little differentiation between the urban and suburban phenomenon of marijuana and related drugs on the one hand, and on the other "soft drugs" such as barbiturates and amphetamines.

While the "grape" has always been with us, the public awareness of the problems swirling about both soft and hard drugs and even the regular drugs is now reaching a fury. The White House has recently created a Special Office for Drug Abuse Prevention, headed by a Doctor Jaffe, who managed a similar program in Illinois. This office is divided into four parts and is aimed at concluding its work by 1975, when hopefully a Special Institute at NIH will be ready. The parts are (1) research and evaluation; (2) management and data, including "coordination" with 17 (yes, seventeen) other government agencies which now separately approach drug problems; (3) demonstration and special task projects, and (4) the program division, which includes treatment and rehabilitation, manpower and education, and direct governmental financial assistance to the 50 states.

This is the presidential response, either to his own perception of the task or his perception of the demand of the public that some "medical" solution be found to the annoying and increasing aspects of drug use and abuse. For this purpose $8,000,000 has been set aside which, matched with the $756,000,000 available to the 17 agencies under presidential contract, seems like a goodly sum to accomplish something.

Unfortunately the matter is not so simple. Money alone, even coordinated under the White House, cannot determine how the drug problem is defined by the American public. Physicians, working all day long with people, can contribute to the definition of drug abuse by their attention to persons who over use any of many drugs, and by their attitudes towards such persons.

Now, I do not mean definition in a verbal sense, for government can come up with fine verbal descriptions of most anything, even for eight million or eight hundred million. But somehow the definition, the attitude about drugs, pushes up from underneath. True, governments can decide on strict or loose limitations, and this sets the style a little. But it is the physician and his patients who determine whether drug use is really drug abuse. And this

dyad determines whether the drug is merely a chemical being misused, or whether it is some demon, as alcohol or heroin are sometimes seen.

We can even help set the stage to determine whether drugs are treated as short range problems, hence requiring specific substitutions like methadone or even legal suppression like amphetamines, or whether the long range scope is to be used and some more sociological, psychological or at least political leverage be applied.

One factor that is new within the last decade or so is the *awareness* of the public of the lack of health care services. In other editorials I've discussed the lack of medical services and how they have come into political focus. Here the point is that for large numbers of persons the lack of inner core facilities and sometimes the lack of availability of services to the vast middle classes produce pressure toward self medication of all sorts. This is catered to by TV ads, patent medicines, and by human resourcefulness, though we might disagree with the wisdom of such resources.

Some government sources are saying that but a few years are left for physicians to act to stem the flow of excess drugs, after which the Justice Department will take over. This is not a threat, it is just a prediction by reasonably responsible persons who function in the wonderland of politics.

When problems of the magnitude of the drug problem come up, it is most difficult to resist the pressures of the now aroused populace to somehow solve it and how little regard for civil or other liberties may result from this sort of massive pressure to solve what is even to those of us in the profession, a relatively incomprehensible puzzle. The action begins, however, when doctor meets patient—and here the habits of thought about drug use are formed.

—RH

Just to Look

We seldom stop to appreciate the simple and direct parts of medical practice. Of course it is not simple at all, although it is direct to look at our patients, to listen to them, and to touch them. I can well remember my chagrin as an intern, upon being called to task for a missed diagnosis, which was due to my simply not having looked, in this case at an "obvious" herpes. Sometimes the simple and wondrous task of looking can be made so much more direct and valuable by the use of new devices. This is amply illustrated by Drs. Hogan, Geenen and De Cosse in this issue *(Diagnostic and Therapeutic Coloscopy: A New Approach to Management of Colon Polyps)*. They most lucidly show the benefits to the patient from educated and facilitated looking, in this instance via coloscopy. It will well repay your reading time.—RH

Current Procedural Terminology: Better Communication—or Semantic Rigidity

In the past several years, recognition of a universal system of nomenclature has led the American Society of Internal Medicine to adopt the five digit coding system. This conforms to the American Medical Association's Current Procedural Terminology, Second Edition.

An attempt is made to use words so that patient, doctor, and the ultimate "payor" all understand what the service was that was delivered. In the portion of the revised edition outline for internists, this requires judgment at the time that a service is delivered. First of all, there is a differentiation as to whether what is done is for a "new patient," or an "established patient." An "established patient" is defined as one "known to the physician and/or whose records are normally available." This, in itself, to many of us is an artificial delegation. Although a patient may be "established," in order to reevaluate such a person thoroughly, it requires the time and expertise of any comprehensive examination. In some ways, it is more difficult to really do justice to an "established patient" than to a completely "new patient." In the "established patients," one is forced to re-think without allowing oneself to get into possibly previous "tunnel-vision thinking," a new approach to the problems that may well be evolving in the "established patient." If one constantly has to think of whether one is doing a "90020" (new patient comprehensive—adult) or a "90080" (established patient comprehensive—adult), it could affect the actual judgment of care delivered.

The same analogy applies to numerous delegations of types of less than comprehensive examinations. When one sees a patient for a cold, is this a "90040" (brief) or a "90050" (limited) type of office call? Many of us divide what we do in Internal Medicine into three basic categories:

1. A complete comprehensive evaluation.
2. An office call.
3. An extended office call which is probably a "one-third" or "one-half complete."

We subsequently charge appropriately, using basically the above three delegations as to what is delivered to patients, new or old.

However, the point about Current Procedural Terminology is not to let it "box us in." If it seems important to so many people that some form of

mutual language be utilized, it behooves us—as internists—to attempt to classify as closely as possible our actual delivered services in the "words" that seem to be necessary for the future of medicine. The Society of Internal Medicine, therefore, urges all internists to get acquainted with, and be comfortable with, and use appropriate categories of service from the Procedural Terminology for Internists, Revised Edition. It further advises physicians in other specialties to utilize codes for specific levels of service which are appropriate to their practice.

FRANCIS N. LOHRENZ, MD, Marshfield
Chairman
Medical Practice Committee
Wisconsin Society of Internal Medicine

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Transport of High-Risk Newborn Infants

A manual on "Transport of High-Risk Newborn Infants" which has been published by the Canadian Paediatric Society merits thorough attention around the State of Wisconsin since our State is particularly involved in transporting sick babies.

A copy of this manual should be in the nursery of every hospital that delivers newborn infants, and should be widely circulated among physicians, nurses, ambulance drivers, hospital administrators, and community planners who are interested in providing the best of care for sick infants.

(Indexed; references; 198 pages. Price, $5.00 each [Canadian funds]. Orders should be sent to: Dr. Victor Marchessault, Executive Secretary, Canadian Paediatric Society, % Department of Paediatrics, Centre Hospitalier Universitaire, University of Sherbrooke, Sherbrooke, P.Q., Canada.)

R. A. BARTA, MD, Madison
Editor
Wisconsin Perinatal Center/News

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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HOW THE
State Medical Society of Wisconsin
SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use and to serve. To benefit fully from membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the third in a series of articles explaining State Medical Society organization and activities.

Society's Auxiliary Gives Time, Money to Health Projects

THE WOMAN'S AUXILIARY to the American Medical Association, celebrating its 50th year, has a membership of 90,000 doctors' wives linked together across the country in state and county units. Wisconsin's Auxiliary is in its 44th year and has 2,000 members working in partnership with their husbands to extend the aims of the medical profession.

The aims of the Auxiliary are the aims of medicine with particular emphasis on medical education and research, medicine in the community, and information programs on medical needs and goals. The changing times have caused doctors' wives to become involved in community projects and to be informed about health care and health related problems and legislation.

The Auxiliary is a strong, purposeful, well recognized organization in which doctors' wives can have a collective voice affecting public policies related to health. Its relationship with the State Medical Society is a close one. The Auxiliary's main office is located at State Medical Society headquarters in Madison, and the Auxiliary is serviced to a considerable extent by Society facilities.

The state Auxiliary budget includes a yearly allotment of $6,000 from the general State Medical Society budget. Out of this, the Auxiliary membership has regularly voted a $500 contribution to the Society's Charitable, Educational and Scientific Foundation (CESF). The state Auxiliary also helps CESF through its annual sale of the Foundation's Christmas card and by distributing envelopes to funeral homes to encourage memorial gifts to the Foundation.

County auxiliaries also make individual gifts to CESF and raise money for scholarships in health manpower fields. This year over $24,000 was awarded to Wisconsin health students.

The AMA's Education and Research Foundation is a similar special Auxiliary project. The two Wisconsin medical schools have received $25,000 through this Foundation's fund-raising efforts.

The county auxiliaries have a number of other projects including meal delivery to shut-ins, blood donor drives, vision and hearing testing programs, homemaker services, health career clubs, visits to the aged, and mental health clubs. Surplus pharmaceuticals, used equipment and books are collected for Direct Medical Relief, Inc., a California organization. The materials are distributed internationally with the help of the "99s", a national women pilots' organization. Many groups also do letter writing to foreign physicians' wives.

In 1971 the Auxiliary contributed $1,000 to the Wisconsin Health Council for the publication of a chart on health careers in Wisconsin. This unique key lists salaries, necessary preparation, scholarships available, and the schools in each allied health career.

The Auxiliary also has sponsored two University of Wisconsin Medical School seniors for a preceptorship in Nicaragua.

Last December the Auxiliary moved to help promote the Museum of Medical Progress in Prairie du Chien, owned and operated by CESF of the State Medical Society. The Aesculapian Society, a museum guild, was formed for physicians' wives who are interested in the Museum and who want to help with its health education exhibits.

Auxiliary members receive two regular publications —*Badger Doctor's Wife*, published in Madison, and *MD's Wife*, the national magazine. All physician wives are encouraged to join their county auxiliary or to become state members-at-large. □

■ *The Auxiliary's Blood Donor Program was recognized for its work by the Milwaukee Blood Center in 1970. Here Mrs. William C. Janssen, now Auxiliary President, is shown with Richard H. Aster, MD (left), Blood Center Director, and Gary A. Becker, MD.*

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THYROID CANCER and Its Diagnosis, Treatment, and Prognosis

Review of the Marshfield Clinic Experience

FRANCIS N. LOHRENZ, MD
Marshfield, Wisconsin

In our patients diagnosed before age 50, thyroid cancer has been limited to the papillary, follicular, or mixed papillary and follicular cell types. Equally, it has been limited to clinical stages I and II.

In marked contrast, patients diagnosed after age 50 include all with undifferentiated cell type, all with stage III disease, and all who have died.

Subtotal thyroidectomy alone has been our most frequent therapeutic approach (26 of 63 patients). Except in stage III disease, all patients so treated are alive, and only one has recurrent thyroid cancer.

THE MARSHFIELD CLINIC experience with cancer of the thyroid is based on complete and continuing follow-up of all 63 patients diagnosed during the twenty years 1952 through 1971 inclusive—30 patients in 1952 through 1965 and 33 in 1966 through 1971.

Because death is the only definite endpoint, and because cancer of the thyroid has a long natural history under any circumstances, therapeutic results are difficult to evaluate. However, the clinical implications of our experience are clear and invite close examination of the data.

Method

This study includes all thyroid cancer patients whose charts are available in the coded records of

From the Section of Endocrinology, Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education, Marshfield.

Reprint requests to: Francis N. Lohrenz, MD, Marshfield Clinic, Marshfield, Wis. 54449.

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TABLE 1—*Thyroid cancer deaths in relation to cell type and stage of disease*

(31 Patients Less Than 50 Years Old at Time of Diagnosis)

Cell Type	Stage I	Stage II	Stage III	Totals
Papillary	0/6	0/8		0/14
Follicular	0/4	0/4		0/8
Mixed Papillary and Follicular	0/4	0/5		0/9
Undifferentiated				
TOTALS	0/14	0/17		0/31

Numerator = deaths. Denominator = number of patients.

TABLE 2—*Thyroid cancer deaths in relation to cell type and stage of disease*

(32 Patients 50 or More Years Old at Time of Diagnosis)

Cell Type	Stage I	Stage II	Stage III	Totals
Papillary		0/3		0/3
Follicular	1/3	0/2	2/3	3/8
Mixed Papillary and Follicular	0/1	1/3	2/3	3/7
Undifferentiated		2/3	9/11	11/14
TOTALS	1/4	3/11	13/17	17/32

Numerator = deaths. Denominator = number of patients.

St. Joseph's Hospital and the Marshfield Clinic. The Clinic's Cancer Registry, (begun by Dr. Gail Williams and currently headed by Dr. W. Z. Zurek) was particularly helpful in determining the up-to-date condition of many of the patients. By review of recent information in charts and letters and by telephone conversations with patients or relatives, follow-up to the end of 1971 was available for all patients. Most patients sought advice because of neck enlargement. The others were referred from the surrounding area (radius 75 to 100 miles).

The histologic type and extent of neoplasm were determined by pathologists at St. Joseph's Hospital. As in our original review,[1] histologic type is based on Dunhill's classification[2] into differentiated (papillary, follicular, or mixed papillary and follicular) and undifferentiated cell types; and clinical stage is based upon the extent of tumor according to Brister et al.[3]

Subtotal thyroidectomy means removal of one lobe with a portion of the isthmus and sometimes an additional portion of the contralateral lobe. Radical neck dissection includes removal of all nodes and the sternocleidomastoid muscle on the side on which it is performed.

Most patients treated since 1960 have received thyroid hormone administered to tolerance.

To determine the general importance of age on diagnosis and prognosis, we divided all patients into those less than 50 years old and those 50 or more years old at the time of diagnosis. Next, we studied the number of deaths in relation to age, frequency of cell types, and frequency of clinical stages. Lastly, to evaluate the outcome of therapy, we assigned patients to one of four surgical groups or to a nonsurgical group.

Results and Discussion

Of our 63 patients with thyroid cancer during the past twenty years, 17 had papillary cell type, 16 follicular, 16 mixed papillary and follicular, and 14 undifferentiated. The distribution by clinical stage was 18 with stage I, 28 stage II, and 17 stage III.

Thirty-one patients were less than 50 years old at the time of diagnosis. They included 14 of the 17 with papillary cell type, 8 of the 16 with follicular cell type, and 9 of the 16 with mixed papillary and follicular cell type. Also, they included 14 of the 18 with clinical stage I and 17 of the 28 with clinical stage II. All 31 are alive, 30 without thyroid cancer. Four are hypoparathyroid. Duration of follow-up is 0.5 to 20.0 years, depending upon date of diagnosis.

Thirty-two patients were 50 or more years old at the time of diagnosis. They included 3 of the 17 cases of papillary cell type, 8 of the 16 cases of follicular cell type, and 7 of the 16 cases of mixed papillary and follicular cell type. More importantly, they included *all* 14 cases of undifferentiated cell type, *all* 17 cases of clinical stage III disease, and *all* 17 deaths in the series. Of 15 survivors, four have recurrent thyroid cancer. Follow-up was .05 to 14.5 years, depending upon date of diagnosis and duration of survival.

Tables 1 and 2 show the number of deaths in the two age groups in relation to the frequency of each cell type and each clinical stage. That is, they show morbidity and mortality by age, clinical diagnosis, and histologic diagnosis. In Table 1 it is strikingly clear that our patients diagnosed before age 50 have had their thyroid cancer limited to clinical stage I or II of the papillary, follicular, or mixed papillary and follicular cell type and that none of these patients has died. In Table 2 it is equally clear that most of our patients diagnosed after age 50 had clinical stage II or stage III disease, more than half had the undifferentiated cell type, and more than half have died.

Also, Tables 1 and 2 show that all papillary carcinoma of the thyroid, regardless of the patient's age

has been diagnosed as stage I or stage II disease, and the patients are living. At the other extreme, undifferentiated thyroid cancer was diagnosed only as clinical stage II or stage III disease, and almost always it has been fatal.

In short, Tables 1 and 2 demonstrate that the patient's age has been the single most important determinant of diagnosis and prognosis, putting us in general agreement with others.[4-8] Table 3 shows the statistical relationship between age and cell type, Table 4 the statistical relationship between age and clinical stage.

Of the 63 cases, 51 were classified according to the type and amount of therapeutic surgery as follows:

1. Subtotal thyroidectomy alone,
2. Total thyroidectomy alone,
3. Subtotal thyroidectomy plus additional concurrent or subsequent measures—neck dissection, chemotherapy, radiation, additional operation on the thyroid or neck, or

TABLE 3—*Relationship of cell type to patient's age at diagnosis*

Cell Type	Age Mean (range)	Standard Deviation
Papillary	33.4 (18 to 79)	±16.3
Follicular	47.9 (16 to 75)	±16.4
Mixed Papillary and Follicular	47.9 (30 to 77)	±14.9
Undifferentiated	66.6 (50 to 89)	±10.4

Statistical significance (Student Fisher t test; N <50)
Papillary vs follicular: $0.30 \leqq p \leqq 0.40$
Papillary vs mixed: $0.30 \leqq p \leqq 0.40$
Papillary vs undifferentiated: $0.02 \leqq p \leqq 0.05$ (significant)
Follicular vs mixed: not calculated
Follicular vs undifferentiated: $0.20 \leqq p \leqq 0.30$
Mixed vs undifferentiated: $0.10 \leqq p \leqq 0.20$

TABLE 4—*Relationship of clinical stage to patient's age at diagnosis*

Clinical Stage	Age Mean (range)	Standard Deviation
Stage I	39.3 (18 to 63)	±13.0
Stage II	43.8 (16 to 89)	±20.1
Stage III	64.7 (50 to 78)	± 8.9

Statistical significance (Student Fisher t test; N <50)
Stage I vs Stage II: $0.70 \leqq p \leqq 0.80$
Stage I vs Stage III: $0.02 \leqq p \leqq 0.05$ (significant)
Stage II vs Stage III: $0.20 \leqq p \leqq 0.30$

TABLE 5—*Outcome of thyroid cancer in 12 patients without surgery of the thyroid*

Patient	Patient's Age/Sex	Year of Diagnosis	Type & Stage of Disease	Treatment	Outcome	Follow-Up (Years)
RD	60/F	1958	Undifferentiated–III	Biopsy	Deceased	0.75
EG	60/F	1960	Follicular–III	X-ray Therapy Chemotherapy	Deceased	0.25
AD	64/M	1965	Undifferentiated–III	Pleural Biopsy	Deceased	0.75
DL	73/F	1965	Undifferentiated–III	Needle Biopsy	Deceased	0.5
EE	52/F	1967	Undifferentiated–III	Chemotherapy	Deceased	1.25
BF	77/F	1967	Papillary and Follicular–III	Radiation to Iliac Crest	Alive With Disease	4.5
MC	75/F	1969	Undifferentiated–III	X-ray Therapy	Deceased	0.5
PW	75/F	1971	Follicular–III	X-ray Therapy	Deceased	0.5
LE	70/F	1971	Undifferentiated–II	X-ray Therapy	Deceased	0.75
MMcG	89/F	1971	Undifferentiated–II	X-ray Therapy	Alive Without Disease	0.75
MB	63/M	1971	Follicular–III	Laminectomy and X-rays to Spine	Alive With Disease	0.5
JM	69/M	1971	Undifferentiated–III	X-ray Therapy	Alive With Disease	0.5

4. Total thyroidectomy plus additional concurrent or subsequent measures—neck dissection, chemotherapy, radiation, additional operation on the thyroid or neck.

By this classification, subtotal thyroidectomy alone is our most frequent therapeutic approach. Of the 26 so treated, only three (all with clinical stage III disease) have died, two from undifferentiated cell type and one from mixed cell type. One living patient has recurrent thyroid cancer, one is hypoparathyroid.

Our experience with total thyroidectomy alone is limited to four patients (26, 33, 34, and 34 years old when diagnosed) and only 4.5 years of follow-up. All four had clinical stage II disease—three papillary cell type and one follicular. All four are living without thyroid cancer, none is hypoparathyroid, and age signals a good prognosis.

The second largest surgical group (13 patients) had subtotal thyroidectomy plus other concurrent or subsequent measures. Six of the 13 patients have died (three from undifferentiated cell type disease, two from mixed cell type, and one from follicular). The six deaths also included three cases of stage III disease, two of stage II, and one of stage I disease. The seven living patients have no thyroid cancer but two are hypoparathyroid. Significantly, the six dead were 58, 60, 63, 63, 76, and 78 years old at the time of diagnosis, again emphasizing the influence of age on the prognosis.

Eight patients received what can be called maximum therapy—total thyroidectomy plus other concurrent or subsequent measures. All eight are alive without thyroid cancer; one is hypoparathyroid. Mean age at diagnosis was 42, and only one patient had undifferentiated cell type (also stage III) disease. Maximum follow-up is 12.0 years.

Twelve patients (Table 5) had no therapeutic thyroid surgery. They were treated by external radiation to the thyroid (5 patients), chemotherapy (1 patient), radiation to the iliac crest (1 patient), x-rays plus chemotherapy (1 patient), or laminectomy plus x-rays to the spine (1 patient), or were not treated at all (3 patients). Most had stage III disease or undifferentiated cell type, commonly both.

These data on therapy show that, in our experience, no single therapy or combination reliably changes the prognosis of any patient with clinical stage III disease of any cell type. Also, they show that subtotal thyroidectomy alone (with suppression) often gives the patient a long and useful life with minimum physical scarring.

ACKNOWLEDGMENTS: This paper itself is an acknowledgment of the contributions from Marshfield Clinic endocrinologists and surgeons throughout the past twenty years. Mr. Albert Zimmermann, the Clinic's Medical Editor, helped assemble the data and prepare the text.

AUTHOR'S NOTE: Complete tables available on request.

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Fournier's Gangrene

JAMES F BURPEE, MD and PHILIP EDWARDS, MD, University of Wisconsin Medical School, Madison, Wis: *J Urol* 107:812–814 (May) 1972

Five cases of scrotal gangrene were reported. Review of approximately 300 previously reported cases suggests that the process may be either idiopathic or secondary to adjacent infection or trauma. These 2 variants occur with about equal frequency. The relationship between host susceptibility and bacterial invasion in the etiology of this disease remains obscure. Antibiotic therapy and topical wound care have reduced mortality to low levels. Delayed closure or the application of split thickness skin grafts results in complete recovery from the illness.

Doctor Burpee is the son of Dr. George F. Burpee, Edgerton, Wis., and is now in practice in Wichita, Kan. □

Fibrin Split Products in the Severely Burned Patient

ALFRED MEYERS, MD, Department of Pathology, St. Mary's Hospital, Milwaukee, Wis: *Arch Surg* 105:404–407 (Sept) 1972

Fibrin split products were measured by a tanned red cell hemagglutination inhibition immuno-assay in 77 patients with burns and 40 normal individuals who were the controls. The severely burned patient showed only a modest elevation of fibrin degradation products. These results did not correlate well with traditional coagulation measurements which may be affected by a number of mechanisms. The level of fibrin split products did not correlate with the percentage of surface body burns, nor was it of predictive value. □

Diagnostic and Therapeutic Coloscopy:

A New Approach to Management of Colon Polyps

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TECHNOLOGIC ADVANCES in design and production of fiberoptic endoscopes have resulted in development of instruments capable of entering hitherto inaccessible areas of the gastrointestinal tract. The coloscope now permits direct inspection and biopsy of the entire colon mucosa. Recently it has become possible to destroy small colonic polyps by electrocautery, and remove larger, pedunculated polyps by snare cautery through the indwelling coloscope. The advent of this capability has prompted a radical revision of our prior concepts for management of patients with polyps of the colon.

The purpose of this report is to review our experience during a six-month interval at the Milwaukee County Medical Complex with 40 coloscopic examinations of patients with colon lesions and to describe how this procedure has altered our approach to the diagnosis and treatment of patients with polyps of the colon.

Methodology

Instrumentation. Initially an early model, 105 cm fiberoptic coloscope was utilized at our Unit. Because of limitations in its length and tip flexibility, however, it has been replaced with a longer (165 cm) polydirectional instrument which permits maneuverability of the intracolonic tip and affords the opportunity to examine the entire colon.* The fiberoptic magnifying lens system and the ability to aspirate, insufflate, and wash through channels in the instrument enables the endoscopist to evaluate the colonic mucosa in great detail. A flexible biopsy forceps and cytology brush permit tissue collection under direct vision. Within the last two years, a flexible coagulation electrode and a snare-cautery instrument have been perfected for fulguration and extirpation of mucosal polyps through the coloscope.

Routine Coloscopy Examination. Usually routine coloscopy can be performed as an outpatient procedure. Preparation of the colon consists of a liquid regimen and 30 to 45 ml of magnesium citrate the evening prior to examination. In the morning, immediately preceding coloscopy, a cleansing enema is administered to the patient by a nurse attendant. Coloscopy is performed on a fluoroscopic table with the patient in the left lateral position. Fluroscopy is useful in following the progress of the coloscope and guiding the tip through the sigmoid and distal colon; it also furnishes valuable information about the anatomic location of visualized colonic lesions, and correlation with the barium x-ray study. A mild sedative (diazepam) is usually administered prior to insertion of the instrument. The coloscope is inserted to maximal length (Fig 1), and during withdrawal, detailed examination is made of the entire colonic mucosa. Biopsies of colonic lesions are taken and their location is recorded accurately. Photographs are taken of each lesion. Routine coloscopy takes from 30 to 45 minutes.

Coloscopy in the Patient with Polyps. All patients undergoing this procedure have had barium enema x-ray examinations with air contrast study of the colonic surface to ascertain location, size, and detail of the mucosal lesion(s). A more rigorous colon cleansing program is initiated. The patient is admitted to the hospital for routine laboratory studies

Figure 1—The 165 cm coloscope has been inserted to the ileocecal valve.

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* American Cystoscope Makers, Inc., Pelham, NY.

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and cleansing enemata. Three days before examination the patient is placed on a clear liquid regimen with elemental dietary supplements (Vivonex[R]) and, one day before coloscopy he is started on oral antibiotics (neomycin). The patient takes an oral cathartic nightly for the three days preceding coloscopy.

Carbon dioxide insufflation is substituted for air insufflation to reduce the potential hazard of explosion at the time of electrocautery in the normal environmental mixture of intestinal gas (predominantly methane and hydrogen).

Polyps are identified, geographically localized, and "mapped" by fluoroscopy, and biopsied when indicated. Small (4 to 6 mm) sessile polyps are biopsied and destroyed by a coagulating electrode. Pedunculated polyps less than 1.5 cm in diameter are transected by snare cautery and retrieved for histologic identification. Sessile polyps of intermediate size (greater than 1.5 cm but less than 2.5 cm) are biopsied or removed depending upon the individual circumstance. Larger polyps (greater than 2.5 cm) are biopsied but customarily are removed later by transabdominal colotomy.

If the appropriate indications for surgery are confirmed by coloscopy, the patient continues his bowel preparation for surgery the following day. If polypectomy is performed at coloscopy, the patient is observed for 24 to 48 hours in the hospital environment before discharge.

Results

There have been no complications in the series of 40 coloscopies in 38 patients. In only one instance was it not possible to reach the suspected lesion with the coloscope. Indications for coloscopy in this group of patients included: colon polyps; colon bleeding; colon obstruction; direct inspection of the mucosa in instances of equivocal radiologic findings; differentiation among granulomatous colitis, ulcerative colitis and ischemic colitis, and distinguishing by direct visualization and biopsy between diverticulitis and carcinoma of the sigmoid colon.

In 65% of the patients in this series, coloscopy modified significantly the strategies for management. Therapy was altered when the coloscopist found additional polyps in areas of the colon other than those demonstrated by radiologic studies, when he was unable to identify polyps which had been described by radiologic examination, when biopsy showed benign disease where a malignant tumor had been suspected and vice versa, and when direct examination of the colonic mucosa provided verification of bleeding diverticula or discriminated among various causes for colonic inflammatory disease.

Of 12 patients with polyps of the colon described by barium enema x-ray examination, the coloscopist confirmed the number and location in four patients, did not find any polyps in two and demonstrated more polyps than had been identified by barium enema examination in six.

Discussion

The importance of coloscopy has been established in the diagnosis and verification of colonic lesions. As a result of coloscopy, treatment of many of our patients has been modified substantially. Often, surgery has been unnecessary because the coloscopist provided visual or biopsy proof of the benign nature of a suspicious or strictured area, or because he was able to remove benign polypoid lesions through the coloscope. When indications for surgery were reinforced by coloscopy, the surgeon was reassured that the entire colonic mucosa had been examined carefully and that he could approach the tumor directly. He was assured further that a questionable mass was not a small infiltrating cancer requiring a more aggressive surgical approach. Coloscopy confirmed the absence of other polyps or identified their presence, reduced or eliminated the need for multiple colotomies and for sterile transabdominal coloscopy, permitted small muscle splitting incisions over the colon pathology and changed an 8 to 10 day postoperative hospitalization to a 4 to 6 day course.

In the past, transabdominal colon polypectomy has carried a substantial complication rate, which may, under some clinical circumstances, exceed the benefit to the patient. These complications, especially infection and incisional and anastomatic disruption, approached a frequency of 20% and have resulted in a 2% to 4% mortality.[1] The complications followed long abdominal incisions, multiple openings in the colon, and the passage of a sterile sigmoidoscope in and out of colotomies with associated contamination of the peritoneal cavity. Now, with the availability of coloscopy, it is feasible to reduce these risks significantly.

Summary

The advent of coloscopy has altered our approach to the patient with colonic disease. Coloscopy has become an increasingly helpful procedure in the management of colon polyps by: (1) localizing definitively all colonic polyps; (2) obtaining information about the histologic nature of the polypoid lesion by biopsy; (3) performing polypectomy through the coloscope in certain instances and eliminating the need for laparotomy; and (4) enabling the surgeon to perform transabdominal excision of colon polyps without the necessity of multiple colotomies with its associated undue risk to the patient.

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

The Painful Shoulder

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BURSITIS IS THE MOST frequent diagnosis for the painful shoulder. It is most often correct, but it is no more specific than the diagnosis of fever. Primary inflammation of the subacromial bursa is rare. Inflammation is most often secondary to lesions in the adjacent tendinous structures. The purpose here is to delineate the criteria for the diagnosis and treatment of the major pain-producing lesions of the shoulder. Several other problems will be mentioned briefly in the discussion.

ANATOMY. The shoulder is a mechanism for transmitting force and motion between the trunk and the upper extremity. When the shoulder is functioning normally, motion takes place at four distinct locations: the sternoclavicular, acromioclavicular thoracoscapular, and glenohumeral articulations.

The joints on either end of the clavicle allow elevation at its acromial end and rotation in its long axis during humeral elevation. If a screw between the coracoid and clavicle is left in place after acromioclavicular repair, humeral elevation will be limited because the clavicular rotation is restrained or the screw will break or loosen.

Although the scapulothoracic articulation is not a true joint, its motion is essential for full humeral elevation. Observation of scapular motion is an essential part of the shoulder examination. During the first 30° to 60° of humeral elevation, the scapula is in the setting phase. The normal pattern of motion during the setting phase is determined by observing the opposite scapula. Usually little motion occurs in the scapula until humeral elevation reaches 30° in the frontal plane or 60° in the sagittal plane. At this point the constant 2:1 ratio commences, that is, for every 2° of glenohumeral motion the scapula rotates 1°. This is termed "scapulohumeral rhythm." This is best appreciated by the examiner placing his thumbs on the vertebral border of the scapula. When, for any reason, motion is limited in the glenohumeral joint, the scapula will move immediately when humeral elevation is attempted. Snapping may develop

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in the area of the superior or inferior angles of the scapula when it moves on the thorax. The "snapping scapula" can be painful. Injections of steroids may help. If bony spurs exist their removal is necessary.

The socket of the glenohumeral joint is very shallow, and articulates with only a small portion of the humeral head. The design of the glenohumeral joint favors large arcs of motion more than it does structural stability. The stability must come from the surrounding soft tissues.

The humeral head is covered by the rotator cuff. This cuff is formed by the merging tendons of the subscapularis, supraspinatus, infraspinatus, and teres minor muscles. The functions of these muscles are to move the humerus and to stabilize the humeral head against the glenoid to allow the deltoid muscle maximal efficiency. The deltoid m., acromion, and acromioclavicular ligament are superior to the glenohumeral joint. The subacromial, or subdeltoid bursa, actually one bursa, lies between the acromion and the deltoid muscle above and the rotator cuff below. It is the largest and most mobile bursa in the body. In the normal state, this bursa facilitates smooth movement of the cuff-covered humeral head beneath the acromion and coracoacromial ligament, a space where little clearance exists. Codman considered this bursa an accessory shoulder joint. Any disease process impinging on this clearance will cause pain or limitation of motion. The tendon of the long head of the biceps runs between the two humeral tuberosities in a tunnel covered by a ligament on into the joint to attach above the glenoid.

Patient evaluation. The history must search for information relating to systemic disease like gout or rheumatoid arthritis. It must be sufficient to rule out neck pathology, most often osteoarthritis. Usage, especially occupational demands, are important. Is trauma related? The character and distribution of the pain must be sought.

The patient must be adequately exposed for examination. Then general posture, muscle atrophy, or muscle paralysis can be observed. The patient with slumped posture frequently has pain along the lateral margins of the trapezii. Paralysis of the serratus anterior m. can be painful because of poor support. The scapular winging cannot be seen if the patient is clothed. Active and passive range of motion are observed. The ranges are not necessarily the same. Scapulohumeral rhythm is observed. Muscle power is tested. Sensory examination may be indicated.

Palpation is for masses, defects, crepitation, and maximal tenderness. The general region is palpated. Tight and painful trapezii are found associated with poor posture, headaches, tension, and neck pain. Specific points to palpate are the acromioclavicular and sternoclavicular joints, the tendon of long head of biceps, and the rotator cuff.

Radiographs are a necessary part of the examination. Ordinary AP views are taken in neutral, internal, and external rotation. A lateral or axillary view is desirable. Any hematologic studies obtained are dictated by the history and the physical examination. Special studies that may be helpful are arthrography, electromyography, and electrical stimulation.

Rotator cuff pathology. The rotator cuff is a tendinous structure subject to hyalin degeneration, loss of fibrillar structure, and focal necrosis. These changes cause a decrease in the strength of the cuff. The decreased strength of aging plus chronic usage encourage microscopic and gross tearing. Any portion of the cuff is subject to tearing, but the supraspinatus portion is subject to the greatest stress and the greatest incidence of tearing. The cuff if torn has little ability to regenerate itself. Few blood vessels exist in this structure in contrast to the overlying subcoracoid bursa that has many vessels. The bursa reacts to cuff pathology with hyperemia and edema. This reaction is painful, and the edema may create a mechanical block to humeral elevation. The degenerative process in the cuff may cause calcium phosphate and oxalate to deposit in the cuff. The supraspinatus portion is the most frequent site for calcium deposition.

Tendinitis of the rotator cuff. This is the most common cause of shoulder pain. No doubt small tears are associated with this problem. Patients older than 35 years are subject to this condition, which may well be a recurrent problem. Symptoms may be insidious or appear after unusual use or minor injury. Night pain can be a problem. The patient frequently grips the convexity of the deltoid when indicating the site of pain. Active elevation is usually limited at about 60° by pain, but early in the disease a full passive range of motion exists. Rotation and elevation may become limited if the disease persists. There is a soreness, maximal at the greater tuberosity, but not exquisite tenderness. Radiographs are usually normal, but after many attacks eburnation, excrescences, small excavations, or partial resorption are seen in the region of the greater tuberosity.

Most pains secondary to tendinitis subside with supportive treatment aimed at alleviating pain and preserving motion. A one or two week course of phenylbutazone followed by aspirin has been found effective; the phenylbutazone is given in decreasing quantities. The aspirin is then given in a regular dosage of 600 mg four times a day. Hot or cold applications may be helpful. If the pain does not subside,

an intrabursal injection of local anesthetic and an appropriate steroid preparation often helps. The injection must be done with strict aseptic precautions. More than one septic shoulder has followed injection with inadequate precautions.

Motion must be maintained. This is best accomplished with what Codman termed "stooping exercises." The patient bends his trunk below horizontal for the humerus to fall into an almost full elevation. The arm is then circumducted like a pendulum with body English. This exercise is performed many times each day. In this position the supraspinatus is relaxed, and the patient is pain free.

It is important that the patient avoid painful activities. A sling may be necessary for a short period. Pain-producing activity only perpetuates the disease process. Sleeping with the arm overhead relieves muscle tension and pain. By swinging the arm down a coat sleeve may be entered. Shaving or hair care can be accomplished without pain by sitting in front of a mirror and passively placing the ipsilateral elbow on an object similar to a box to keep it elevated. This allows free use of the hand in the region of the head without contraction of the cuff muscles.

A small proportion of patients are resistant to the outlined treatment. They are then a candidate for a partial acromionectomy.

Calcific tendinitis. The pain of calcific tendinitis comes on acutely in the middle-aged patient. It may be spontaneous; it may follow minor injury or overuse. The pain is severe. Night pain can be excruciating. Active elevation is limited and painful. Passive motion is normal. Exquisite tenderness is present above the deposit usually in the supraspinatus tendon. Radiographs will show the deposit. The views in different rotations are helpful for visualizing the deposit. Not all calcium deposits are painful, and may be an incidental finding.

If left untreated, the pasty deposit will become solid over a period of many days or weeks and the pain will subside. All the measures mentioned for tendinitis are used plus potent analgesics. The "chemical boil" that exists may spontaneously rupture into the subacromial bursa, and the pain will soon resolve as the calcium is resorbed.

This resorption process may be hastened by local anesthetic and steroid injection. Accuracy in hitting the deposit can be improved with the aid of fluoroscopy. The patient must be warned that the pain may become more severe after this injection. Two needles may be inserted, and the deposit removed by injecting saline or local anesthetic in one needle and aspirating with the other. If the deposit is large and causes recurrent attacks or mechanical impingement, it may be removed surgically.

Rotator cuff tear. With this condition, a tearing sensation is usually experienced after severe injury in a middle-aged heavy worker. There is a delay of several hours between injury and onset of pain. Pain subsides, and function improves in a few weeks after a small tear, but not after a large tear. In a few weeks, supraspinatus m. and deltoid m. atrophy is present. A palpable defect may be felt in the rotator cuff. Active elevation is again limited. If the humerous is passively elevated to 90° and the support is suddenly removed, the arm will drop. The best diagnostic aid is an arthrogram. If contrast medium injected into the joint enters the subacromial bursa, a tear is present. The therapeutic dilemma is deciding on the magnitude of the tear. Small ones will resolve with the tendinitis treatment, but surgical repair is the procedure of choice for a large tear.

Adhesive capsulitis, or frozen shoulder. This may be primary or secondary. Secondary disease may follow any condition that limits shoulder motion. Primary disease is typically seen in middle-aged females. The onset of pain is insidious, then becomes severe with associated night pain, and resolves after many agonizing months.

With a frozen shoulder, active and passive motion are restricted. The therapeutic modalities listed for tendinitis are used. When acute symptoms subside, attempts at regaining motion must be vigorous. In addition to Codman's exercises, a pulley system, or finger climbing a wall may be prescribed to gently stretch the adhesions. Manipulation under anesthesia can break the cycle. The patient must exercise intensively after a manipulation.

Bicipital syndromes. Attrition allows the tendon of the long head of the biceps in the bicipital groove to become inflamed, hypermobile, or ruptured. Bicipital tendinitis may occur alone or with rotator cuff tendinitis. The maximal tenderness is in the bicipital groove. Pain is produced by resisted forearm supination or resisted humeral flexion from the extended position. The therapeutic principles for cuff tendinitis are used. If the intertubercular ligament becomes attenuated, the biceps tendon can sublux. The symptoms are those of biceps tendinitis, but a spontaneous painful click is experienced associated with external rotation. The click can be felt with light palpation while externally rotating the humerus. If severe, the tendon is surgically anchored to the proximal humerus.

The tendon may rupture with attrition and produce the "popeye" muscle bulge. It may be ignored in the elderly, but in others it is repaired surgically.

Acromioclavicular arthritis. This produces pain, tenderness, and crepitation over the acromio-

clavicular joint. Radiographic changes are those of degenerative arthritis. Most patients respond to supportive treatment. Steroid injection may be used. Very few patients warrant resection of the distal clavicle, but this procedure removes the joint and the pain.

GLENOHUMERAL ARTHRITIS. This is rarely a problem. Radiographs show true glenohumeral osteoarthritis. Treatment is symptomatic.

Recommended for Further Reading

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Cost Analysis of Wisconsin's Program of Multiphasic Health Screening

T H SCHWARTZ, BS, JOSEF PREIZLER, MD, Wisconsin Division of Health; R H LAESSIG, PhD, State Laboratory of Hygiene, Madison, Wis: *Health Services Reports* 87:523–529 (June–July) 1972

The laboratory costs of a state-sponsored, statewide multiphasic health screening program in Wisconsin were analyzed. Included in the analysis were the costs of processing a person from the time he entered the blood sampling station until the results of his screening were presented to a medical reviewer. The overall cost per person was $3.85.

In addition to analysis of blood samples with an SMA 12/60 12-channel multi-element chemical analyzer and a single-channel glucose AutoAnalyzer, the screening included an evaluation of blood pressure, the taking of a personal medical history, and a chest x-ray film. The actual cost of processing a blood sample (excluding the cost for personnel who collected the specimens in the field) was $2.35. □

The Connective Tissue Nevus-Osteopoikilosis Syndrome

W F SCHORR, MD, Marshfield, Wis; J M OPITZ, MD, Madison, Wis; and C N REYES, MD, Marshfield, Wis: *Arch Dermatol* 106:208–214 (Aug) 1972

This study is concerned with the clinical manifestations and histopathologic findings in six cases of osteopoikilosis from two, possibly related, families. Only three of the six individuals involved had skin lesions. These could be considered as falling with the defined, but nonspecific, spectrum of connective tissue nevi. Within these connective tissue nevi in the various affected members we found histopathologic changes ranging from collagen hyperplasia to elastic fiber hyperplasia to elastic fiber deficiency consistent with a broader definition of connective tissue nevus.

Three individuals from two families gave a history or were found to show manifestations of an earlier-than-normal onset of puberty which is thought to be the cause of the shortness of stature of two of the adults with this symptom. The combination of osteopoikilosis, connective tissue nevi, and "precocious" puberty is considered a syndrome which was found to be dominantly inherited in both families. □

Esophageal Atresia and Tracheoesophageal Fistula in Association with Bronchial and Pulmonary Anomalies

W M TOYAMA, MD, Marshfield, Wis: *J Pediat Surg* 7:302–307 (June–July) 1972

We recently treated an infant who had esophageal atresia and tracheoesophageal fistula plus bronchoesophageal fistula, congenital tracheal stenosis, and agenesis of the right main-stem bronchus. Only one other patient with virtually identical findings has been reported (Keeley and Schairer 1960). These two and other related cases in the literature suggest the need to consider associated pulmonary abnormalities (although rare) in infants with esophageal atresia and tracheoesophageal fistula.

Before surgical closure of the tracheoesophageal fistula, the right lung was aerated by air passing from the trachea, through the tracheoesophageal fistula, down through the distal esophagus, thence through the (right) bronchoesophageal fistula. Hypoplasia of the right lung might have been suspected preoperatively from the smaller right lung in some of the chest films. Before surgery, the stenosis permitted a barely adequate airway. Following intubation and surgery, edema and secretions were sufficient to compromise the critically narrow lumen. Transient dilation of the stenotic trachea and removal of retained secretions probably explain the improvement that followed each intubation.

Although the abnormalities of our patient may be extremely rare, the combination is not unique. The significant findings are a short proximal esophageal pouch associated with a high tracheoesophageal fistula, evidence of unilateral lung hypoplasia, and symptoms of tracheal obstruction or persistent unilateral atelectasis.

Tracheal stenosis is the crucial factor contributing to death. Early recognition of the anomalies may lead to appropriate studies and corrective surgery. Because of its critical nature and high mortality, the combination of stenosis or atresia of the larynx or trachea with esophageal atresia and tracheoesophageal fistula should be emphasized. An awareness of this combination may improve the survival odds of these severely affected infants. □

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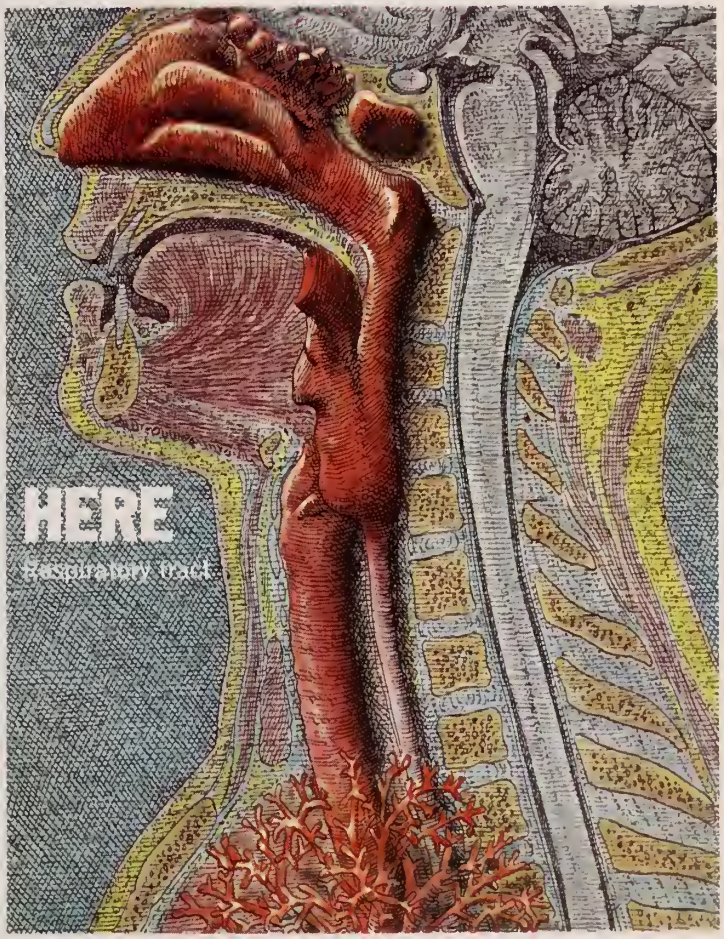

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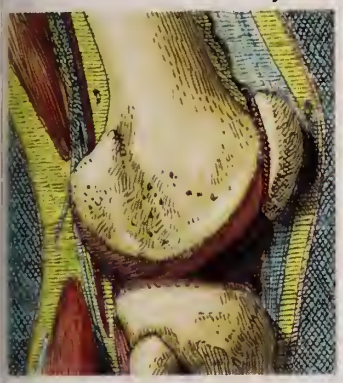


ıerever it hurts, Empirin mpound with Codeine usually ɔvides the symptomatic ief needed.

IERE Headache

flu and associated respiratory ection, Empirin Compound ;h Codeine provides an titussive bonus in addition to ief of pain and bodily ›comfort.

prescribing convenience: up to 5 refills in 6 months, your discretion (unless stricted by state law); by ephone order in many states.

ıpirin Compound with deine **No. 3,** codeine osphate* 32.4 mg. (gr. ½); **. 4,** codeine phosphate* .8 mg. (gr. 1) *Warning—may habit-forming. Each tablet so contains: aspirin gr. 3½, enacetin gr. 2½, caffeine ½.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

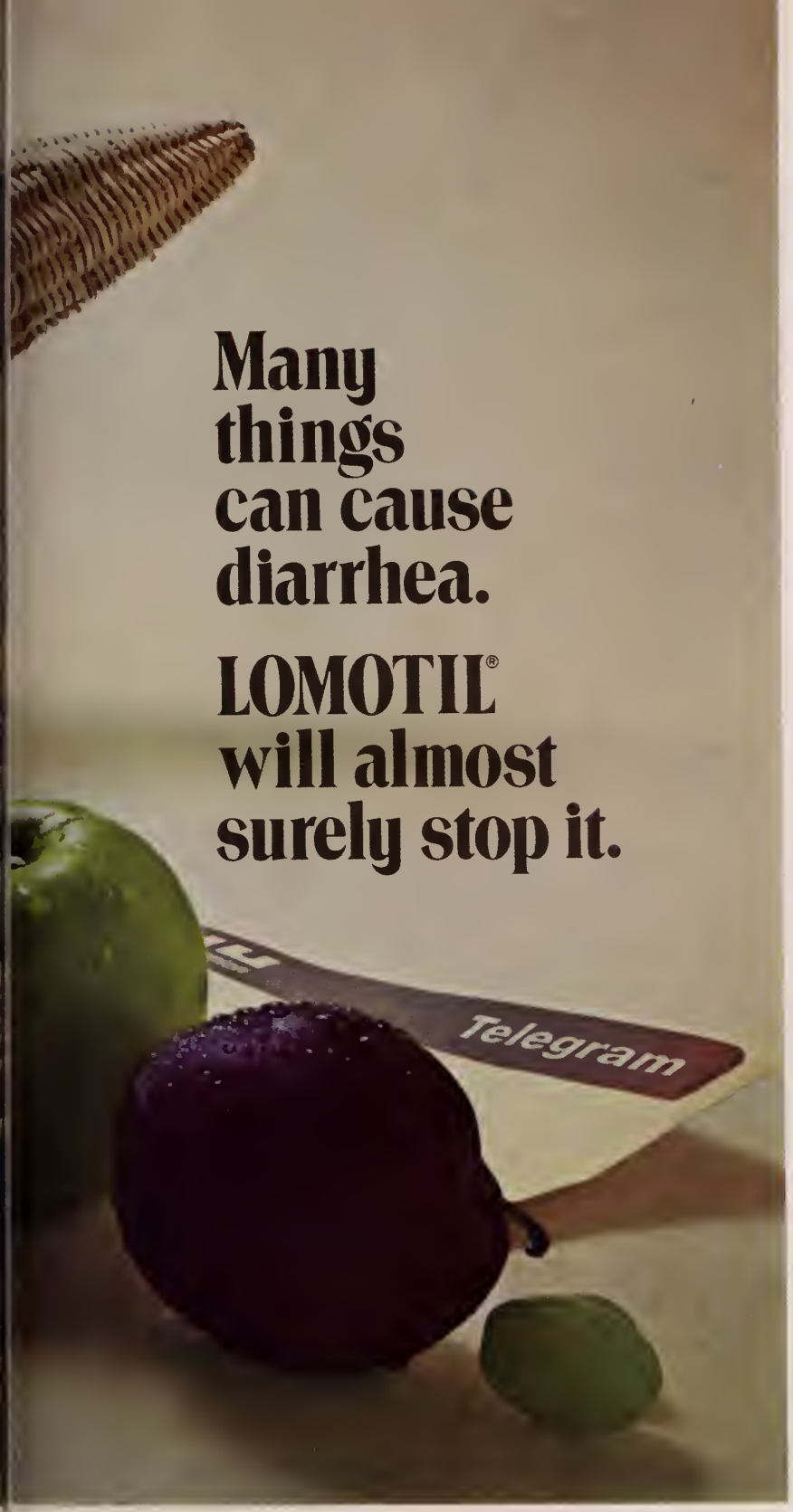
Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to dipher late HCl is theoretically possible at high dosage not exceed recommended dosages. Administer caution to patients receiving addicting drug known to be addiction prone or having a histo drug abuse. The subtherapeutic amount of atro is added to discourage deliberate overdos strictly observe contraindications, warnings and cautions for atropine; use with caution in chil since signs of atropinism may occur even wit recommended dosage.

Adverse reactions: Atropine effects include dry of skin and mucous membranes, flushing and nary retention. Other side effects with Lomoti clude nausea, sedation, vomiting, swelling of gums, abdominal discomfort, respiratory depres numbness of the extremities, headache, dizzi depression, malaise, drowsiness, coma, leth



Many things can cause diarrhea.

LOMOTIL® will almost surely stop it.

The causes of diarrhea are as varied as man's complaints and indiscretions. Because the causes of diarrhea can be obscure and because uncontrolled diarrhea can present serious problems, it is important to know a drug that will usually stop diarrhea promptly. For many physicians, the antidiarrheal drug of choice is Lomotil. It provides almost certain control of diarrhea.

It is also useful in controlling the intestinal transit time of patients with ileostomies and colostomies and the diarrhea occurring after gastric surgery.

Serious side effects are infrequent with Lomotil. It should be used with caution in young children, however, because of their variability in response. Use of Lomotil in children under two years of age is contraindicated.

For the almost certain control of diarrhea,

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
Diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: may be habit forming)
Atropine sulfate ..... 0.025 mg.

rexia, restlessness, euphoria, pruritus, angioneu-
: edema, giant urticaria and paralytic ileus.

age *and administration:* ***Lomotil is contraindi-
d in children less than 2 years old.*** Use only
:otil liquid for children 2 to 12 years old. For
s 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years,
l. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5
s daily; adults, two tablets (5 mg.) t.i.d. to two
ets (5 mg.) q.i.d. or two regular teaspoonfuls (10
5 mg.) q.i.d. Maintenance dosage may be as
as one fourth of the initial dosage. Make down-
d dosage adjustment as soon as initial symptoms
controlled.

rdosage: Keep the medication out of the reach
hildren since accidental overdosage may cause
re, even fatal, respiratory depression. Signs of
dosage include flushing, lethargy or coma, hypo-
c reflexes, nystagmus, pinpoint pupils, tachy-
lia and respiratory depression which may occur
12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

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WISCONSIN MEDICAL JOURNAL
Vol. 72, No. 3 MARCH 1973

Medical
STATE MEDICAL SOCIETY OF WISCONSIN
GREEN SHEET

ANNUAL MEETING

Reports Set Future Society Course

When the State Medical Society's House of Delegates meets in March it will act on a number of recommendations by Society Committees and Commissions.

(Resolutions by county medical societies and scientific sections were printed in last month's GREEN SHEET.)

The following recommendations are made in the activity reports submitted to the House of Delegates.

Ad Hoc Committee on Districting. This committee was formed last year under instructions from the 1972 House of Delegates. Its purpose was to review the Society's districting for representation on the Council.

It reported that the present districts "are not as responsive to the needs of the membership as they could be" if they more accurately reflected the local pattern of practice.

Such considerations include rural or urban practice, geographic referral patterns, and health planning activities.

The Committee's redistricting proposal maintains the requirement of one councilor for each district up to 250 members, and one additional councilor for each 250 members or major fraction thereof.

The proposal follows the lines of comprehensive health planning (CHP) areas, but three CHP areas are subdivided: Southeastern District 1 (subdivided into districts 1A, 1B and 1C), Southern District 2 (subdivided into districts 2A, 2B and 2C) and Lake Winnebago District 5 (subdivided into districts 5A and 5B).

The Committee suggests that consideration be given to amending Article IX of the Constitution which specifies 13 councilor districts. It believes this would permit more flexibility in Council structure.

Commission on Scientific Medicine. Three recommendations:

1. *Annual Meeting*—Honoraria for out-of-state guest speakers be increased from $100 to $200.
2. *Commission Membership*—Section chairmen, or program chairmen of the sections, be made members of the Commission.
3. *Continuing Medical Education*—The Commission to be a coordinating committee responsible for the development of a provision for information on continuing medical courses available in Wisconsin and neighboring states.

Division on Aging. The proposed implementation of an Institute on Gerontology through the University of Wisconsin has been discussed with the Division. The Division recommends that the House recognize that medicine has a very significant role and professional concern in the area of gerontology.

If there is adequate representation from the Society in the planning, development, and administration of the proposed institute's program, then the Society should officially endorse this concept.

The Division also strongly recommends that the House reaffirm its previously adopted policy stating that "compulsory retirement in employment policies which reject workers solely because of age, waste valuable human resources and contribute to physical and mental illness among the aged."

The Society should continue to oppose Senate Bill 50 which would make retirement mandatory at age 65 for state and local government employees if it became law. The Society has long expressed its opposition to this type of legislation.

The Division's position is that the State of Wisconsin should lead industry and labor by adopting truly flexible retirement programs which recognize individual worth and initiative.

Division on Alcoholism and Addiction. The Division recommends that the House of Delegates endorse the following recommendations of the Governor's Health Planning and Policy Task Force:

1. All general hospitals should have and maintain detoxification facilities or units for treatment of alcoholism and drug abuse as a condition of licensure, if no other specialty hospitals exist or are immediately available for treatment of these conditions.
2. Mental health clinics should give top priority to the development of adequate pre-care and after-care programs for severe and chronic disabilities: the psychotic, the alcoholic, the drug abuser and the developmentally disabled.
3. Insurance coverage should be extended to a range of outpatient care for mental illness, alcoholism and other drug abuse such as partial hospitalization, day care, rehabilitation, halfway houses and other alternatives to 24 hour

care, with no exclusions for services in public facilities.

4. Insurance coverage should also include treatment in public institutions or facilities as well as voluntary facilities.
5. Coverage should be extended to include treatment of alcoholism on an outpatient and inpatient basis to all group and individually held policies.
6. There should be required training in alcoholism and other drug abuse for all health and mental health professionals. The State Bureau of Alcoholism and Drug Abuse should take responsibility for developing appropriate curricula.
7. A preventive approach to mental health should be adopted through special training programs for primary care health professionals and others most likely to have contact with young children and their parents. A cooperative effort between the State Division of Health and the State Division of Mental Hygiene should develop appropriate curricula.

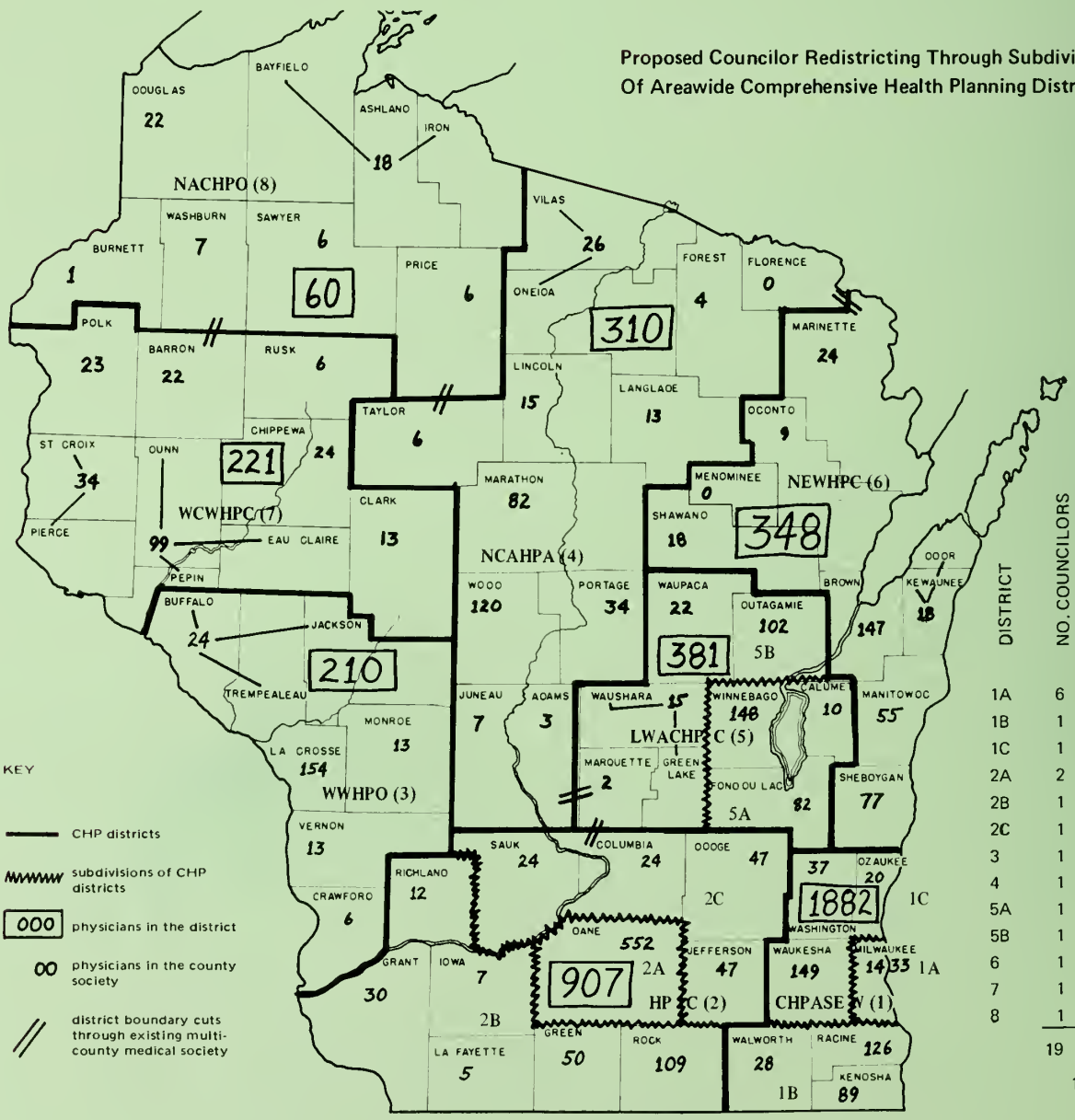
Other recommendations by the Division are:

1. Teaching programs and information on detoxification procedures should be established. Purpose would be to provide adequate information within the state. Funding should be sought for the development of such a program under the auspices of the medical schools.
2. The Division also recommends to the House that it go on record opposing the availability of codeine substances in cough syrups except on *prescription-only basis.*

Division on Ear, Nose and Throat. Three recommendations:

1. *Examinations for Hearing Aids*—Where possible, every child 16 years of age or younger, should have an examination by a board certified otologist and an audiologist who holds a certificate of clinical competency from the American Speech and Hearing Association before being fitted with a hearing aid. It is further recommended that this position, where feasible,

Proposed Councilor Redistricting Through Subdivision Of Areawide Comprehensive Health Planning Districts



DISTRICT	NO. COUNCILORS	NO. MEMBERS
1A	6	1433
1B	1	243
1C	1	206
2A	2	552
2B	1	213
2C	1	142
3	1	210
4	1	310
5A	1	240
5B	1	141
6	1	348
7	1	221
8	1	60
	19	4319

12/31/72

should be reflected in state law and administrative regulations.

2. *Hearing Testing for Children*—The Society should formally state that it looks with favor on the progress being made by the State Department of Public Instruction in hearing testing for preschool and school children and that all physicians should be encouraged to cooperate with the Department's testing programs.
3. *Screening for Medicaid Recipients Under 21*—The Federal proposal to create "early and periodic screening, diagnosis and treatment for Medicaid recipients 21 and under" should definitely be structured to avoid duplication with currently existing programs. Strong consideration should be given to setting up such centers in connection with the University of Wisconsin system throughout the state.

Division on School Health. The Division has reviewed recommendations of the Governor's Health Planning and Policy Task Force and recommends the following policy guidelines:

(a) The several agencies of state government which now deal with health education need to have their services coordinated so that we can do a more effective job.
(b) The educational aspects of health should come before the service concept when dealing with school environment.
(c) Initial programs, to be effective, should start by comprehensively educating high school aged students in the role of parenthood. This will provide a continuum for good health practice. In addition, the educational process should be started in the first five years of life.
(d) Health education must be integrated into the total curriculum from K–12 and not be fragmented.
(e) Schools should become the facility for preventive health maintenance, but should not be used in such a way that they fragment the health care delivery system.
(f) Emphasis should be given to the creation of special physical education programs for the handicapped child in order to provide rehabilitation.
(g) Occupational health standards for teachers and other school employees need to be reviewed and upgraded. Present requirements for health examinations for teachers are minimal.
(h) The present autonomy of school districts makes it difficult to create uniformity. All districts must, by Statute, meet certain criteria in the area of health education if a successful program is to be initiated.

The Division further recommends to the House of Delegates that careful consideration be given by any new state study group to defining whether the schools will be used as a facility where services can be delivered or whether the schools will not only be the location but also through their staffs actually will be delivering services.

Division on Vision. These recommendations:

1. *Vision Care Benefits*—The House of Delegates should ask that the Council assure that WPS benefits for eye examinations and eyeglasses are designed to provide for proper reimbursement based on the type of services rendered.
2. *Vision Screening Manual*—The manual "Eye and Vision Screening in the Preschool and School Years" should not be substantially changed by the State Department of Public Instruction. The screening standards used in school and preschool programs should be those adopted by the National Society for the Prevention of Blindness.
3. *Legislation*—The Society should SUPPORT proposals:
   (a) Calling for the use of safety glasses in certain academic classes; and
   (b) Creating a Dispensing Opticians Examining Council within the State Medical Examining Board. The Society should OPPOSE any attempts to change the current statutory definition of optometry in a manner which will not adequately safeguard the public.

Commission on Safe Transportation. These recommendations:

1. *Child Restraining Systems*—The Society should strongly support the concept of greater use of child restraining systems as adequate devices become available.
2. *Legislation*—Support:
   (a) A 0.10 level of alcohol for presumption of intoxification for drivers;
   (b) Creation of an official Medical Advisory Board for the State Division of Motor Vehicles;
   (c) Ambulance service certification standards; and
   (d) Use of seat belts in school buses (when the buses are constructed to warrant such use).

Council. These recommendations:

1. *1974 Dues*—No dues increase in the coming year. Dues should remain at $145 for 1974.
2. *Revision of Constitution and Bylaws.* Adoption of the revision as set forth in the annotated Constitution and Bylaws contained in the Delegates' handbook.
3. *Reorganization of WPS*—WPS should be reorganized by the Commission on Medical Care Plans under Chapter 611 of the Wisconsin Statutes, preferably as a stock insurance corporation, or in the alternative as a mutual insurance corporation. The assets and business of WPS should be transferred to such corporation, including the assumption of all WPS liabilities. If the Insurance Commissioner turns down incorporating under Chapter 611 as a stock company, the matter will then be brought back to the Council before there is approval of the mutual route. □

EMS

Favorable Prognosis

Although the demise of the Wisconsin Regional Medical Program (WRMP) seems imminent, many of its projects will live on.

Its biggest, the fledgling $1.2 million Emergency Medical Service (EMS) project, was given a favorable prognosis last month by WRMP coordinator, John Hirschboeck, MD.

Dr. Hirschboeck told the EMS Task Force that EMS is a 1972 project and thus safe from the President's 1973 budget trimming. What he didn't know was where EMS administration will land in the federal bureaucracy.

All RMPs are scheduled to self-destruct on June 30. Sometime this month Dr. Hirschboeck hopes to learn more about the method that will be used.

EMS was launched only last July, with the largest grant ever given to a single RMP project. In its three-year lifespan it was slated to tie together statewide communications networks and establish emergency training programs.

To date only the skeleton organization is in place. The Task Force, the EMS governing body, held its third meeting February 16.

Much of the concern at that meeting was with a key piece of legislation that may determine the outcome of EMS. Some wrinkles in Assembly Bill 538, creating a council to license ambulance attendants, were examined by the group's legislative committee in a special meeting.

Working with State Senator James Devitt, it has since whittled out an amendment that removes objectionable features from the bill. Specifically the group took out a section that would have led to classifying and certifying hospitals on the basis of their emergency services.

EMS is now surveying hospitals, using AMA guidelines, to determine exactly what type of emergency and other care they can provide. The plan is to report to the Legislature on this survey and other EMS developments in January 1975. At that point some consideration may be given to hospital classification.

A major requirement of Assembly Bill 538 is that a licensed ambulance attendant must complete training prescribed by the State Department of Health and Social Services and pass a Department test.

The Task Force also heard reports from the area-by-area EMS councils and on EMS projects.

The statewide emergency radio network that is the heart of EMS is on the way. This will link, by microwave, emergency vehicles, hospitals, police dispatchers, and other emergency agencies throughout the state. Bids are now being taken for the equipment by the State Division of Highway Safety Coordination.

When the network is in place, physicians called in the middle of the night on a highway accident will be able to speak from

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

SMS committees *in action*

Residency Training Programs. Commission on Hospital Relations and Medical Education, January 18, approved and supported the recommendation of the Governor's Health Planning and Policy Task Force to expedite a residency training program in Wisconsin. If the Task Force's recommendations are adopted, funds will be provided to assist in establishing residency programs in areas of Wisconsin where no such programs now exist.

Basic Immunization. Division on Maternal and Child Welfare, December 8, agreed that all children should receive basic immunization. Anything less than 90 percent is unacceptable. Division members agreed that the State Medical Society, working through its component county societies, together with the Wisconsin Academy of Pediatrics, the Wisconsin Academy of Family Physicians, and the Division of Health, should do whatever is necessary to accomplish basic immunization throughout the state without delay.

Nurse Midwife. Division on Maternal and Child Welfare, February 17, announced the formation of a subcommittee to evaluate the role of the nurse midwife in Wisconsin. Chairman is R. Dale Hunsaker, MD, chief of the Maternal and Child Health Section of the Wisconsin Division of Health.

Older Drivers. Commission on Safe Transportation and the Division on Aging, January 10, recommended that the Society support research in the area of developing standards for the older driver. Commission and Division members also asked that the Society support the concept of an individual giving blank consent for medical information to be forwarded to the Motor Vehicle Division when that individual signs his application for licensure.

Child Restraining Systems. Commission on Safe Transportation, January 10, suggested that insurance companies, the Jaycees, AAA, and the National Safety Council should be among the groups to call the attention of the public to the need for child restraining systems. The Commission is recommending that the House of Delegates support the concept of greater use of these systems.

Antibiotics in Milk. Division on Maternal and Child Welfare, February 17, resolved to make application for state and federal grants to assist in research toward identification of the presence of antibiotic residue in raw-produced milk and finished-product milk. □

their bedside to the patient or attendant at the scene. By "patching in" the physician's telephone via inexpensive equipment in the hospital, the patient can be under direct physician supervision all the way from the accident scene to the hospital.

The State Division of Health reported that its survey of hospital emergency departments has been completed. Now, using AMA guidelines, Wisconsin hospital emergency departments will be categorized on the basis of the care they can provide. When this is done, ambulances can be directed by the radio network to the appropriate emergency department for the patient they are carrying.

At the February 16 meeting of the Task Force a number of research projects on EMS equipment and training programs were reported including:

- A study of walk-in emergency room patients by Frederick Tavill, MD (Fox Point). He is looking at the problems presented by these patients at Milwaukee County Emergency Clinic and the Milwaukee County General Hospital Emergency Department.
- A training course for emergency medical technicians by MDs Joseph Darin (Milwaukee) and Claude Taylor, Jr. (Madison). Dr. Taylor's course is well underway and has graduated two groups of fire fighters. Dr. Darin's course is now experimental but is expected to be in use shortly. Dr. Darin also has held a seminar for nurses and may repeat it annually. He has EMS training for postgraduate medical students on the drawing boards.
- A prototype EMS vehicle by Leonard Worman, MD. The first goal is to develop a miniature equipment package to aid in giving sophisticated care at the scene. Once this is done, the best emergency vehicle to hold the equipment must be found.

The Task Force also was told that nine coordinators have recently been named to organize the EMS councils. These in turn must set up the committees that will do most of the work in each area. The coordinators are working within the comprehensive health planning agencies ("B" agencies) to set priorities. □

ANNUAL MEETING

Rx for Workmen's Comp.

When a worker was hurt on the job at the turn of the century, that was generally the end of the story. Even if his earning power was cut off for months or years, he could not count on financial help unless he won a long, expensive court suit.

The story has a brighter ending with today's Workmen's Compensation laws. Yet the complexity of space age medicine has followed closely on the heels of more humane laws. Problems have arisen because most Workmen's Compensation systems, (including Wisconsin's) have no provision for medical advisors.

One result is that the give and take of medical debate in a disputed case can lead to questionable awards. Physicians unaccustomed to testifying at hearings can be put in the position of seeming to disagree. Examiners and attorneys then conclude that medical knowledge is uncertain and subject to diverse theories. In fact, conflicts are more often due to the problems inherent in presenting medical evidence under the adversary system.

An exhaustive study of the problems in Wisconsin Workmen's Compensation system was

An Opportunity

An opportunity for Society members to influence policy for the next year is the reference committees of the House of Delegates at the Annual Meeting this month. These four committees will discuss proposals for House action submitted by county medical societies and scientific sections of the State Medical Society.

Committee meetings will start at 7:00 pm Sunday, March 25, in Milwaukee's Pfister Hotel. Members of the reference committees and their hearing locations are:

Reports of Officers (Taft Room)

Drs. Patricia J. Stuff, Bonduel, Chm
L. L. Thompson, Green Bay
A. C. Costello, Milwaukee
D. J. Carlson, Milwaukee
M. L. Janssen, Adams

Reports of Standing Committees (McKinley Room)

Drs. J. K. Scott, Madison, Chm
DeLore Williams, Milwaukee
Henry S. Ashe, Woodruff
M. F. Purdy, Janesville
A. J. Sanfelippo, Milwaukee

Resolutions and Amendments to the Constitution and Bylaws (Imperial Ballroom)

Drs. T. J. Foley, Milwaukee, Chm
J. J. Tydrich, Richland Center
F. M. Bannister, Chetek
R. D. Heinen, Oconto Falls
George V. Murphy, Milwaukee

Finances (Richard II Room)

Drs. A. H. Stahmer, Wausau, Chm
W. E. Wright, Mondovi
P. G. LaBissoniere, Milwaukee
D. B. Comin, La Crosse
P. O. Simenstad, Madison

Also at that time, the Planning Committee will hold an open hearing in the Roosevelt and Kennedy Rooms. This committee has proposed a number of changes in the State Medical Society's Constitution and Bylaws. It is particularly interested in learning of any needed changes in committee structure or duties. It will continue its open hearing on Monday, March 26, from 2 to 4 pm in the Empire Room.

Members of the Planning Committee are:

Drs. W. R. Manz, Eau Claire
G. A. Behnke, Kaukauna
T. J. Doyle, Superior
R. F. Lewis, Marshfield
W. F. Smejkal, Manitowoc
E. J. Nordby, Madison

completed last year by Milwaukee rehabilitation specialist George A. Hellmuth, MD.

Wisconsin, the first state to enact a Workmen's Compensation law, measured up well in a state-by-state comparison published in Washington last July. The National Commission on Workmen's Compensation Laws found that, like most states, Wisconsin needs a better medical advisory system.

Doctor Hellmuth's proposal for such a system was studied by the State Medical Society's Committee on Occupational Health. The Committee agreed unanimously that there should be top level consultation and input between medical sources and the Workmen's Compensation Division of the Wisconsin Department of Industry, Labor and Human Relations.

The Committee also agreed with Doctor Hellmuth's suggestion that there should be better supervision and coordination of rehabilitation facilities and procedures available to the industrially disabled. Currently, according to Doctor Hellmuth, the law's provision for full rehabilitation is often frustrated by poor coordination between the Workmen's Compensation Division, insurance carriers, attending physicians, and rehabilitation centers.

At its meeting this month, the House of Delegates will be asked to act on the Committee's recommendations, which also include a request for increased medical education on occupational health problems. □

CESF

Help for Neopit

At long last, Menominee County has a doctor. But that's about all.

The National Health Service Corps brought Michael Reinardy, MD, to the county last year. But since then he has been struggling along with minimal equipment and supplies.

Now, with the help of the Society's CES Foundation, the picture has improved. Donations from several Wisconsin physicians and physicians' widows have brought a small Christmas in March to the Neopit Community Health Center for Dr. Reinardy, his nurse and community health assistant.

DR. REINARDY LOOKING AT SUPPLIES
Christmas in March

An EKG machine, diathermy unit, ultra violet light, assorted specialized instruments, and drugs were brought to Neopit by State Medical Society Councilor Robert Heinen, MD, Oconto Falls. Dr. Heinen offered his personal help to the center and the Foundation is continuing its search for specialized equipment to expand the center's services. □

DRIVING

Drawing the Line

Should a diabetic drive a car? How about someone who is grossly overweight or who has an artificial leg?

The examiner for a driver's license faces a myriad of medically related problems, but he shouldn't have to refer all of them to a physician.

Last month Wisconsin examiners took part in a pilot program designed to help them learn where to draw the line.

For example, the examiners were told that a diabetic taking oral medication or controlling the problem with diet alone presents no problem. However, the diabetic on insulin should be evaluated by a physician.

The overweight applicant or one with an artificial leg can best be judged in an on-the-road test.

DR. WEYGANDT SPEAKING TO EXAMINERS
Don't always ask the doctor

If the examiner finds he does a good job, he should have a license.

This is the type of information the conference provided. Talks by a team of five physicians were arranged by the American Medical Association and the American Association of Motor Vehicle Administrators. An ophthalmologist, psychiatrist, neurosurgeon, cardiovascular surgeon, and a family physician talked to some 60 driver examiners and their supervisors from across the state. They outlined how various physical and mental conditions affect an applicant's ability to drive and gave guidelines to suspect conditions that should be referred to a physician.

One reason the pilot program was in Wisconsin is James Weygandt, MD, Sheboygan Falls. He has long been active in highway safety programs at the state and national levels. He currently heads the State Medical Society's Commission on Safe Transportation and the Governor's Advisory Council on Highway Safety.

He was the family physician on the program. The other MDs, from Philadelphia, Louisville, and Atlanta, were members of the AMA's Committee on Automobile Safety.

Other states are also interested in the program. It was videotaped for use in training the remainder of Wisconsin's licensing personnel. If the materials meet expectations, they will then be available to other states.

Funds are being supplied by the Insurance Institute for Highway Safety and the Highway Users Federation, both of Washington, D.C. □

CESF

Valuable Assets

The Society's CES Foundation has nearly 100 trustees. The fact that only ten of them are designated non-medical trustees is misleading. For the non-medical trustees have proved to be among the board's most valuable assets.

The three newest bring special talents to the board:

Audrey Baird, Wauwatosa, is extremely active in many Wisconsin art, education, and civic groups. The wife of William W. Baird, MD, Mrs. Baird's philosophy is that "there's a lot more to health besides the physical."

Her interest in the arts stems from a lifelong love of music. She has a bachelor's degree in music education from the State University College at Potsdam, N.Y., and has directed music education in Hampton Bays, N.Y., Cincinnati, O., and Hempstead, N.Y.

She is the originator of two Milwaukee Symphony presentations for young people—the Kinderkonzerts and the Young Artists Auditions and Concert.

She is president of the executive coordinating committee of the Mid-America Ballet. President Nixon appointed her chairman of the Wisconsin Arts and Culture Committee last fall.

Mrs. Baird is vice-president of the Milwaukee World Festival and the Wisconsin Arts Council. She is secretary of the Wisconsin Symphony Orchestra Association and Young Audiences, Inc., of Wisconsin.

She is a member of the board of directors of the Milwaukee Florentine Opera Company (and was founding president of the Company's Opera Club), the Milwaukee Symphony Orchestra, Wisconsin College–Conservatory, Wisconsin Dance Council, Women's Council of the American Symphony Orchestra League, Alverno College, National Friends of Public Broadcasting, and the Friends of Channel 10 Community Broadcast Council.

Her many activities include both state and county medical society woman's auxiliaries. She has served as president of the Woman's Auxiliary of the Medical Society of Milwaukee County.

MRS. BAIRD

DR. SMITH

MRS. MC DOWELL

She also has served as president of the Suburban Woman's Club of Wauwatosa.

She has been given awards for her work by the Milwaukee Symphony, Theta Sigma Phi, and the Wisconsin Federation of Music Clubs.

She was given Wauwatosa's Distinguished Citizen Award in 1969 and last year was the recipient of the Mount Mary Pro Urbe Award.

Dr. and Mrs. Baird have three children, Bruce, 24, Brian, 23, and Barbara Jan, 18.

Nancy McDowell, Fox Point, is public affairs account executive at the Milwaukee public relations firm of McDonald Davis and Associates. Her projects chiefly involve the National Conference of State Legislative Leaders, which keeps legislators in touch with their counterparts in other states.

The Milwaukee-based group is made up of the presiding officers, majority and minority leaders, and key committee chairmen of state legislatures. Its periodic national and regional meetings are designed to help the states cope with such knotty problems as revenue sharing and school financing. Robert Knowles, president pro tem of the state Senate, is a past president of the 13-year old group and a member of its executive committee.

Currently, the organization is wrestling with the dilemma for state budgets if the Nixon Administration cuts funds for categorical aids programs.

Mrs. McDowell has been with McDonald Davis since 1965 and became a member of its advisory board in 1971. Her previous business experience preceded the birth of her children, R. Scott, now 19, and Patricia, 15.

Her husband, Robert, is a regional supervisor of the auditing department of Maryland Casualty Company in Milwaukee. After she became a CESF trustee, it was discovered that she had been a State Medical Society employee in 1950.

James Morton Smith, PhD, Madison, has been director of the State Historical Society of Wisconsin since September 1970. He also is a professor of American history at the University of Wisconsin.

Dr. Smith's background will be a valuable asset to CESF's Museum of Medical Progress on the site of Prairie du Chien's old Fort Crawford. One of his major interests is making history meaningful to laymen. At the State Historical Society, he oversees six historic sites which attract nearly 400,000 visitors each year, a museum, and a manuscripts and book library in addition to a variety of scholarly research and writing projects.

Dr. Smith has written books on George Washington, colonial history, American constitutional development, and the Alien and Sedition Laws. Books in progress include one on the Kentucky Resolutions in connection with American civil liberties, and annotations for letters between Thomas Jefferson and James Madison.

Dr. Smith is secretary–treasurer of Wisconsin's American Revolution Bicentennial Committee. He also is executive vice-president of the Historic Site Foundation, secretary of the Wisconsin History Foundation, and state liaison officer for historic preservation in Wisconsin.

Before coming to Wisconsin, Dr. Smith was a professor of American history at Cornell University. He also has taught history at Butler University, Ohio State University, the College of William and Mary and Duke University. He received his doctorate from Cornell University in 1951. □

STAT

After a year of warning physicians what will happen if they don't post the fee schedules and signs required under Phase 2 economic guidelines, **Phase 3** is here, changing all that. Price schedules and signs are no longer required in physicians' offices or health-care institutions. Phase 3 regulations published in the January 12 Federal Register do continue wage and price controls on the health industry, however. This was called "discrimination against physicians" by the Chairman of the AMA Board of Trustees. John R. Kernodle, MD, wrote President Nixon protesting that while lawyers' fees went up 14% and physicians' fees only rose 2.7% nationwide, MDs are the only professionals under the controls. The AMA may not continue its "spirit of cooperation" into Phase 3, Dr. Kernodle told the President.

■

A special seminar on the role of the **medical director** in the long-term care facility is being sponsored by the AMA in Chicago, April 6–7. Planned with the U.S. Department of Health, Education, and Welfare's Community Health Service arm, the conference is accredited by the American Academy of Family Physicians. Preference will be given to applications from physician–administrator teams or from individual physicians. There is no registration fee. Contact the AMA Department of Hospitals and Health Facilities or the State Medical Society's Public Information Department for further details.

■

Chiropractors might have gotten more than they bargained for when they were brought under Medicare by the Congress last fall. Next July when they begin asking for the money, they will have to demonstrate spinal subluxations by x-ray. And who will be looking at the x-rays? Physicians in Professional Standards Review Organizations, according to HEW Undersecretary John Veneman.

DR. HOLDEN:
GRASS ROOTS FOR THE BOARD

For the second year in a row, AMA trustee, **Raymond T. Holden, MD,** will attend the State Medical Society's Annual Meeting. Along with the other AMA board members, he is keeping in touch with grass roots sentiment by making the rounds of state medical society conventions. The Board started the custom last year when Wisconsin was the first state to hold open hearings on the AMA's future.

■

Speaking of the Task Force, some of its bills are starting to roll into the Legislature. As predicted, one would create a public utility for health care **(Health Services Commission).** Most controversial powers would be control over physician offices—construction, licensing, quality of care, and cost. Close inspection of the bill reveals a bureaucratic layer cake and an administrative hodegpodge, according to State Medical Society Secretary, Earl Thayer. Society alternatives are to beef up, not emasculate, the Division of Health and to use ongoing rate and review programs such as Wisconsin Health Care Review, Inc. and the Blue Cross–WHA rate review plan. The bill (AB 489) is now in the Assembly's Health and Social Services Committee. Committee chairman, Joseph Czerwinski, is one of the bill's 15 sponsors.

DR. AND MRS. JOHNSON:
FLOWERS FOR DOCTORS

If you see red on March 30, doctor, relax. The Woman's Auxiliary to the State Medical Society is hoping to festoon the state's physicians and their communities with red carnations to observe "Doctors Day." The idea was started 39 years ago by a Georgia woman and made a nationally recognized observance by Congress in 1958. The project is the first of **Mrs. Robert Johnston,** in her term as Auxiliary President, which starts at the State Medical Society's Annual Meeting this month.

■

Kudos for the overwhelming physician response to the State Medical Society's call for **Nicaragua volunteers.** The suburban Milwaukee Shinners group of weekly newspapers said the avalanche of MD offers to help Managua earthquake victims should remove any "doubt about the integrity of the medical profession in Wisconsin." The editorials appeared in the Wauwatosa, Brookfield, and Elm Grove newspapers. The salute was also sent out over the wires by UPI chief, Ray Doherty.

■

Because of conflicts with other meetings, the American Medical Association has changed the date of the **Midwest Conference on Health Quackery** to be held in Madison. Now it is scheduled for Saturday, May 12, at the Edgewater Hotel. The State Medical Society will be hosting this general conference. All Wisconsin physicians are invited to attend. Representatives from 12 surrounding states also will be invited. □

WPS

report

for Wisconsin Physicians

Volume 1 Number 2 March 1973

Professional Services Review

Increasing public emphasis on consumer protection, concern from influential group health insurance buyers for both quality care and adequate cost control, and general concern over costs is bringing attention to health care.

As a result, the term "peer review" is creeping into medical journals and periodicals. Emphasis is placed upon potential review of physicians' patterns of medical practice.

Hand-in-glove with "peer review" is the term "PSRO" which means Professional Standards Review Organization. This is a legal term to describe the federal government's attempt to set up peer review committees for Medicare patients. Information is being distributed both pro and con relative to the implications of recent PSRO legislation. The legislation applies primarily to people over age 65 thereby leaving a large percentage of the population currently unaffected by PSRO requirements.

We at WPS consider "peer review" as a potentially effective program to help monitor medical costs. Therefore, we are developing "in-house" peer review requirements.

WPS is committed to working with guidelines supplied through Wisconsin Health Care Review, Inc., an independent corporation whose Board membership represents the State Medical Society of Wisconsin, State Dental Society, Wisconsin Hosptial Association and consumers.

WPS Holds Down Administrative Costs

At a time when it's popular to talk about the high cost of administering Medicare, Wisconsin Physicians Service (WPS) is setting records for low administrative costs.

WPS is one of three lowest cost Medicare contractors in the nation. Medicare is federal health insurance for the aged. The low ranking for both the Chicago region and the nation was announced by the Bureau of Health Insurance at Baltimore, Md.

WPS cut administrative costs to a low $2.07 per unit against a national average of $3.18 per unit cost. Production per man year at WPS is at 5,582 claims compared to the national average of 3,590.

WPS administers Medicare in Wisconsin, except for Milwaukee County. The Madison-based health insurer is a nonprofit Blue Shield Plan that has administered Medicare since 1966, when the national health plan originated. WPS also administers Medicaid and CHAMPUS, federal health insurance for certain needy people and military dependents, in Wisconsin.

Report is New

This is the second *WPS Report for Wisconsin Physicians.* The *Report* is a bimonthly service to physicians and their medical assistants. It is perforated and punched so that it may be torn out and kept in a three-ring binder for future reference. News for physicians appears on the front page and tips for your medical assistant in processing claims are on the back page. We invite your comments, just write: *WPS Report for Wisconsin Physicians,* Box 1109, 330 E. Lakeside St., Madison, Wisconsin 53701.

and their *Medical Assistants*

TIPS for Medical Assistants

ON WORKMEN'S COMPENSATION

• On our present claim report, we ask for information to determine whether or not Workmen's Compensation is involved. We also ask if a claim report is being submitted to another insurance carrier. It is extremely important to us that both of these questions be answered to the best of your knowledge.

You may ask, "Why does WPS need to know if a claim involves Workmen's Compensation? If Workmen's Compensation is involved, I don't need to submit a claim to their office." While this is true in many instances, we are sure you would be surprised at the number of claims that are submitted to our office in which we do determine that Workmen's Compensation is involved. Therefore, when you are submitting a claim for injury to WPS and the claim involves the subscriber, please be especially careful to determine whether or not Workmen's Compensation might be involved.

ON NONDUPLICATION

• Almost all WPS group health insurance does have a coordination of benefits or nonduplication clause. Basically, this contract benefit states that we will not duplicate insurance benefits paid by another insurance company's group policy. Whenever you know of the possibility that other group insurance might be involved, please note on the WPS claim report. This will speed up processing for your claims, as we will not have to contact the subscriber for this information.

We may not eliminate all the headaches connected with a coordination of benefits provision, but you might be interested to note that in 1972, WPS "saved" almost onehalf million dollars by not duplicating payments . . . a strong effort to keep premium down. WPS health insurance is meant to provide health care and is not meant for profit on illness. In 1973, WPS will save subscribers even more as coordination of benefits is added to all group insurance contracts.

Medical Assistants of the future visited WPS claims offices in February. The in-service training is part of their course of study at Madison Area Technical College. They are left to right: Mrs. Eleanor Derge, RN, Madison, Mrs. Johnnie Smith, WPS Claims Adjuster, Sue Behnke, Fond du Lac, Margaret Vander-Woude, Randolph.

Tear out and file with series in three-ring binder

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autions—Toxic amblyopia has been reported long-term continuous use of ethchlorvynol. nanent visual defects have been observed, al- gh amblyopia has improved after discontinua- of the drug. Drug dosage should be limited elderly and debilitated patients to the smallest ctive amount. If pain is present, this drug ld only be given if insomnia persists after is controlled with analgesics. Caution is ad- d in prescribing the drug for patients who are g treated with either MAO inhibitors or anti- ressants. Transient delirium has been reported the combination of Placidyl and amitryptyline. g dosage should be reduced if prescribed for ents receiving MAO inhibitors or antidepres- s. Caution should be exercised in patients impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alco- or who exhibit excitement and release of inhi- n in association with such agents, may also t in this way to Placidyl. Rarely, patients may bit symptoms suggestive of an unusual sus- tibility to the drug; such as prolonged hypnosis, ound muscular weakness, excitement, hysteria, yncope without marked hypotension. Transient iness or ataxia may occur.

erse Reactions—Hypotension, nausea or vom- , gastric upset, aftertaste, blurring of vision, iness, facial numbness, and allergic reaction fied by urticaria have been reported following idyl administration. Mild "hangover" and symp- s of mild excitation have occurred in some ents. There have been rare reports of cholestatic dice occurring in patients taking ethchlorvynol. ew cases of thrombocytopenia have been re- ed in patients receiving ethchlorvynol. 302430R

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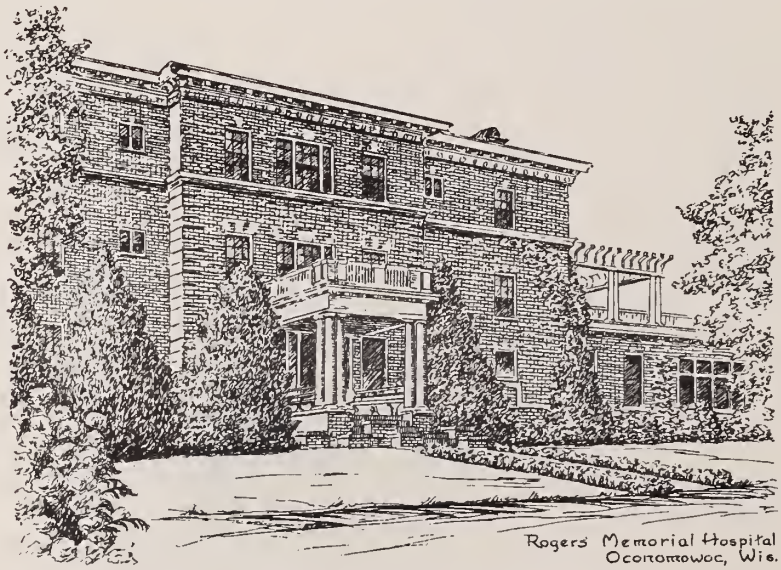

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COUNCIL MINUTES—State Medical Society of Wisconsin

MADISON, NOVEMBER 11, 1972

1. Call to Order and Roll Call

The meeting was called to order at 1:30 p.m. at the State Medical Society by Chairman Nordby, with administration of the oath of office to Councilor Beilman.

Voting members present: Doctors John Foley, Olsman, Nordby, Huth, Beilman, Edwards, Smejkal, Mauthe, Dettmann, Rohde, Heinen, Lewis, Manz, Doyle, Egan, La Bissoniere, Williams, Pittelkow, Meyer; Past President Behnke; President Purtell; Speaker Nereim.

Others present: President-elect Derus; Doctors Collentine, Picard, Carlson, Twelmeyer, Russell, Kief, AMA delegates and alternates; Messrs. Thayer, Maroney, Reynolds, McIntyre, Brower, Johnson, LaBissoniere, Waldschmidt, Murphy, Kluwin, Gill; Mmes. Davenport and Anderson; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Mauthe–Edwards, carried, minutes of July 29, 1972, were approved.

3. Reports of Council Committees

A. Executive Committee

(1) Mediation of UCR Fee Disputes with Surgical Care

Doctor Purtell supplemented information previously provided the Council on the committee's attempts to mediate disputes between county medical societies and Surgical Care over the determination of usual, customary and reasonable fees, by reporting on the November 10 meeting with members of the Surgical Care board of directors. He indicated that agreement had not yet been reached on a method of adjudication; that Milwaukee County has again been requested to consider the committee's proposal for utilization of the Council Committee on Peer Review with appeal to the Council if necessary; and that in the meantime representatives of Dane County have met with Surgical Care in an effort to resolve the problem for that particular locality.

(2) Peer Review: Immunity for participants and confidentiality of records and information

The committee presented preliminary drafts of legislation on these two aspects of the conduct of peer review which were approved in principle on motion of Doctors Dettmann–Huth, carried.

(3) 1972 Work Week of Health Survey

The committee reported for information on the results of a survey of physicians attending the Work Week of Health as to its format and content.

(4) Physician Shortage

The committee presented a proposed letter to legislators as recommended by the Special Committee on Shortage of Physicians intended to pinpoint areas in the state where they believe true shortages of physicians exist; also to elicit their views on the use and availability of allied health personnel.

On motion of Doctors Lewis–Dettmann, carried, the Council approved release of such a communication with copies to presidents of county medical societies.

(5) JCAH Regulations on X-ray Interpretations

On motion of Doctors Behnke–Dettmann, carried, the Council approved the recommendation that the Wisconsin delegation be encouraged to speak to this matter at the AMA level, whether by introduction of a resolution or some other means.

(6) Blue Cross–WHA Rate Review Program

The Executive Committee and the Commission on Medical Care Plans recommended that the Society accept an invitation to appoint a member to a Blue Cross committee charged with reviewing rate increase requests and rendering decisions, subject to appeal, on the acceptance or rejection of such requests. In addition to nine members appointed by the Blue Cross Board of Directors, the committee is to consist of the President of Blue Cross, the Executive Director of the Wisconsin Hospital Association, and one appointee each selected by the WHA board of trustees, the Wisconsin Conference of Catholic Hospitals board of trustees, the Governor, the State Medical Society, and the Medical Society of Milwaukee County.

On motion of Doctors Egan–Edwards, carried, the Council authorized appointment of a Society representative by the Chairman of the Council.

On motion of Doctors Huth–Egan, carried, the Council approved the report of the committee as a whole, including information contained in committee minutes since the last Council meeting.

B. Economic Medicine

The Council received minutes of the committee's October meeting with information as to the status of its ongoing review of membership benefit programs. Doctor Heinen reported on the morning's meeting in further review of existing insurance coverages as well as proposals under study, including group Workmen's Compensation coverage and an automobile leasing plan. The committee recommended that the Society also investigate key man insurance on certain employees.

On motion of Doctors Edwards–Doyle, carried, the Council requested that the Committee on Economic Medicine investigate key man insurance and continue its other studies for later report to the Council.

C. Planning

The committee presented in the form of amended bylaws a number of recommended revisions previously reported to the Council having to do primarily with relocation and renumbering of provisions relating to membership qualifications and categories.

In addition, the Planning Committee recommended that the Editorial Board consist of the Medical Editor as chairman and six additional members elected by the Council, and that the Editorial Board be in charge of the affairs of the *Wisconsin Medical Journal,* subject to the direction of the Council on policy.

On motion of Doctor Manz, seconded and carried, the Council approved this recommendation and included in bylaw revisions to be acted upon by the House of Delegates the deletion of the following wording from Chapter VII, Section 2: "It (Commission on Scientific Medicine) shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates."

The committee further recommended the following new wording in reference to the duties of the Commission on Scientific Medicine:

"The Commission on Scientific Medicine shall study, develop and present programs of postgraduate and continuing education for the membership through the State and component societies and in such other ways as it may find feasible. It shall serve as the Society's coordinating body with similar education programs for physicians and allied health personnel in cooperation with the medical schools in Wisconsin and other governmental and voluntary organizations having a proper interest in this field. It shall assist the specialty societies in their postgraduate and continuing education endeavors. It shall work with the Society's peer review mechanisms to influence self-assessment and self-improvement through scientific programs among the members of the Society.

"The Commission shall also study the character and scope of the scientific proceedings of the Society and prepare the scientific program for the annual meeting."

The Planning Committee reported further that it has begun a review of the entire structure of Society com-

mittees and commissions for the purpose of recommending changes, and suggested that Councilors assist the President-elect and Chairman of the Council by submitting names of qualified members to assume committee and commission positions.

Finally, the committee recommended that it conduct a scheduled hearing during the 1973 annual meeting and invite all committee and commission chairmen to inform the Planning Committee of how the Society can best assist them in implementing their assigned work and to what extent some activities can be lessened.

On motion of Doctor Egan, seconded and carried, this recommendation was approved by the Council.

On motion of Doctor Rohde, seconded and carried, the Council accepted proposed revisions in the Constitution and Bylaws as submitted to date by the Planning Committee for transmittal to the House of Delegates for action at the 1973 annual meeting.

D. Finance

(1) 1973 Budget

On motion of Doctors Smejkal–Williams, carried, the Council approved the general fund operating and capital expense budgets as recommended by the Finance Committee. No change in dues was proposed and it is anticipated that 1973 income will exceed expenses by approximately $18,000 for addition to reserves.

(2) 1972 Special Assessment for Educational Program on Chiropractic

It was reported that some members had not yet paid the $10 assessment voted by the House of Delegates in May.

On motion of Doctor Lewis, seconded and carried, the Council reconsidered its interpretive action in May and determined that only full dues paying members would receive another billing and face loss of membership for failure to pay the assessment.

Amendments of this motion were adopted to provide that the final billing be sent by certified mail, return receipt requested, and the alternative recommended by the Finance Committee be offered of contributing a like amount to the CES Foundation; further, that members receiving the billing be encouraged to discuss it with their councilor if they wish. Council members were provided with a list of those who had not paid the assessment.

On motion of Doctor Huth, seconded and carried, the Council accepted the report of the Finance Committee.

4. Report of Ad Hoc Committee on Districting

The Council received copy of the proposed plan of redistricting the state according to comprehensive health planning boundaries as communicated by the ad hoc committee to officers of county medical societies, and a summary report of comments received to date from the county societies. The committee requested any comments or suggestions from the Council before preparing its final report to the House of Delegates.

On motion of Doctors Egan–Edwards, carried, the report of the ad hoc committee was accepted as meeting the terms of the resolution adopted by the House requesting the study, without implying approval or disapproval of the redistricting proposal.

5. Governor's Health Planning and Policy Task Force

The Council had received a report on actions of the Task Force at its October meeting. These had been discussed by the Executive Committee the prior evening, which recommended that the Council support Mr. Thayer's proposal to file a minority report with the Task Force prior to its final meeting, especially relating to regulation, and after publication of the final report that an analysis be presented by the State Medical Society to include both what it is for and what it is against. It is contemplated that various committees and commissions will be utilized in reviewing parts of the final report prior to determination of the Society's position, some of which has been done already.

On motion of Doctors Edwards–Egan, carried, the Council approved the recommendation of the Executive Committee.

6. Federal Legislation

Mr. McIntyre supplemented summary information provided the Council on H.R. 1, Social Security Amendments of 1972, as enacted by Congress and signed by the President, with particular reference to Professional Standards Review Organizations (PSRO) provisions.

Mr. Thayer presented a statement for Council consideration on PSRO in relation to the Council Committee on Peer Review and Wisconsin Health Care Review, Inc.

On motion of Doctors Dettmann–Rohde, carried, the Council approved the statement and implementation of its recommendations, both recorded in full as follows:

"The foresight of the Council and the House of Delegates in sponsoring the formation of Wisconsin Health Care Review, Inc. and the Council's designation of its Committee on Peer Review as the medical component of WHCRI is exemplified by recent congressional developments. WHCRI was proposed and organized in the public interest as a vehicle for shared responsibility in assuring continued high quality of patient care through voluntary participation of the medical and allied professions.

"Now that H.R. 1, 92nd Congress, is the law of the land there is the need for both review and reaffirmation of some previous actions. The creation of designated Professional Standards Review Organizations (PSROs) is a major element of H.R. 1. There are some basic concepts of PSRO with which the State Medical Society is in accord. These include: (1) quality of medical care may only be evaluated by peer review; (2) peer review should be accomplished on as broad and integrated a spectrum of disciplines as is practical; and (3) peer review activities (programs) must develop in a manner that will include state and federal programs of financing health care.

"Moreover, medicine lauds the PSRO requirements for broad practitioner participation, periodic rotation of those engaged in the review process, as well as the publicizing of peer review programs to assure public knowledge and understanding. With regard to inpatient services, the new law encourages pre-admission review and the use, when the medical needs of the patient can adequately be served, of more economical alternative facilities. These, too, are consistent with the purposes and objectives of the Committee on Peer Review and WHCRI.

"However, like other federal health care legislation, the PSRO portion of H.R. 1 vests substantial regulatory power in the Secretary of HEW. This being the case, there is the real possibility that regulation may respond unduly to the financial exigencies of a given moment rather than to the needs for health care quality. The result might diminish the exercise of independent professional judgment which is so essential to proper patient treatment. In this area, the State Medical Society and the AMA must be alert and willing to exercise constructive leadership, not merely critical protest, in seeking to assure the development of a sound peer review program.

"Among the obligations of the Secretary is to designate all PSRO areas no later than January 1, 1974. Another is that in any state containing three or more PSROs the Secretary establish a Statewide Professional Standards Review Council and appoint its membership.

"A PSRO must review institutional (inpatient) services and may, upon request to the Secretary, undertake review of other health services. Also, a PSRO may use and accept findings of hospital review committees if these committees meet certain criteria. Within the components of WHCRI the capability exists to arrange for review of all aspects of health care. And although PSRO is applicable only to federally funded programs, there are seeming advantages to an integrated and coordinated system of quality maintenance rather than to encourage multiple agencies with the attendant added costs and confusion of overlapping programs involving the same providers.

"Nowithstanding some negative aspects of the PSRO legislation, which are inevitable in legislatively designed regulation, including certain punitive functions (as distinguished

from corrective measures through education), consideration should be given to recommending that Wisconsin be considered as a single statewide PSRO area.

"It is therefore recommended that the Council:

"1. Reaffirm the concept of a coordinated statewide peer review (quality maintenance) program and the designation of its Committee on Peer Review as the medical component of WHCRI;

"2. Re-emphasize, pursuant to previous House of Delegates action, the necessity for creation of peer review committees in each component medical society, or as an alternative by districts to serve physicians in several counties—the goal being implementation of WHCRI statewide;

"3. Urge the Wisconsin Hospital Association to recommend to its member hospitals that their respective utilization review programs function within the framework of WHCRI;

"4. Recommend to the Board of Directors of WHCRI that it analyze its current structure and consider the feasibility of making any necessary adjustments to be the Statewide PSRO;

"5. Authorize a statewide leadership conference on PSRO and WHCRI, jointly sponsored by the State Medical Society, State Dental Society, and Wisconsin Hospital Association, at the earliest possible date involving county medical and dental society officers, chiefs of hospital staffs, hospital administrators, the officers of the SMS, SDS, and WHA, plus other invited guests; the purpose of such a conference being to provide uniform information to the medical, dental and hospital leadership in Wisconsin concerning the implementation of PSRO legislation, suggest methods of jointly achieving the goals of WHCRI and PSRO, and explore specific first steps for meeting the requirements of PSRO in the state; and

"6. Request the Council Committee on Peer Review to study PSRO as it affects Wisconsin, the State Medical Society, the county societies, and the membership, these relationships with WHCRI, the development of PSRO legislation to effect T-19 in Wisconsin, and to make any indicated recommendations to the Council."

7. Report of AMA Delegates

The Council accepted an informational report on behalf of the delegation, including comments on the first meeting of Wisconsin representatives in its new alliance with the states of Ohio, Michigan, Illinois, Indiana and Kentucky. Doctor Nordby reported that he had transmitted the decision to withdraw from the North Central Conference.

8. Commission on Medical Care Plans

On motion of Doctor Edwards, seconded and carried, the Council accepted the following quarterly report from the Commission:

Report of the Commission on Medical Care Plans to the Council—November 11, 1972

The WPS Health Maintenance Plan has been implemented in Dane County, with 6,500 persons enrolled effective November 1. The Plan provides a broad range of in- and out-of-hospital benefits, with reimbursement to physicians on a combination fee for service and fixed monthly health maintenance fee as contrasted with typical full capitation programs in other parts of the country. (See the descriptive brochure enclosed [not reproduced here but available upon request].) Similar plans have been implemented in Green, Waushara, Richland, Pierce and St. Croix Counties, covering a total of approximately 2,900 persons enrolled. In other areas of the State, through cooperation with local medical communities, full fee-for-service experiments are being considered.

The Commission has directed that all cases involving questions of medical necessity be referred to Wisconsin Health Care Review, Inc. WHCRI has been officially notified, and several cases are being finalized on which advice will be requested.

The recommendation to the Governor and the Health Planning and Policy Task Force that State funds be used to help cover health care costs of the uninsurable and unemployed resulted in adoption by the Task Force of this concept for the uninsurable, with no action taken on the latter recommendation. The CMCP has on its pending agenda consideration of a statewide health insurance plan. Recommendations will be provided the Council when completed.

Financial statements already provided the Council indicate a continuing favorable result in 1972. Mid-year budget review shows the management staff will stay within the established budget for the year 1972.

A study of the WPS investment portfolio has been accomplished, including a meeting with investment counselors Scudder, Stevens & Clark. The Executive Committee of the Commission will meet quarterly with investment counselors to assure thorough communication and hopefully an upward trend in portfolio earnings. At the same time, serious consideration is being given to the use of other investment consulting organizations.

Staff has been directed to prepare recommendations regarding separate incorporation of WPS for Commission approval and subsequent approval by the Council. Legislation will be introduced during the 1973 term requiring separate incorporation of the Blue Plans. Action by the Society to establish the form of the separate corporation is indicated at this time.

A vision care benefit providing payment for eye examinations and eyeglasses has been developed for inclusion in the WPS portfolio to the extent that such services are permitted by law. Payment will be made to those licensed to provide such services or supplies. This health care benefit will result in the accumulation of "cost" statistics currently not available in WPS records.

These items are an update on Executive Committee or Commission activity since the last report to the Council.

Respectfully submitted,
E. M. Dessloch, MD, Chairman
Commission on Medical Care Plans

9. Commission on State Departments Election

On motion duly made, seconded and carried, Henry Veit, M.D., of Milwaukee, was elected chairman of the Division on Nervous and Mental Diseases.

10. Ad Hoc Committee on Chiropractic

Doctor Williams reported on two meetings of the committee since the last Council meeting, its plans for the preparation and distribution of educational materials on chiropractic, and preliminary thinking of the committee in reference to a legislative program.

The committee recommended to the Council that it accept the Medical Examining Board's definition of acupuncture as constituting the practice of medicine and surgery, and further that the subject of acupuncture be referred to the appropriate Society committee for the development of guidelines to assure that acupuncture will not be used in Wisconsin without adequate research.

On motion of Doctor Williams, seconded and carried, this was referred to the Commission on Scientific Medicine.

11. Committee of Eight

The Council received an informational report on the status of discussions by this committee.

12. WISPAC

Doctor Behnke presented the recommendation of the WISPAC board of directors that the Council approve voluntary billing for WISPAC membership along with Society dues beginning with the 1973 statements. After discussion of the pros and cons, the recommendation was approved on motion of Doctors Behnke–Williams, carried.

The Council recessed to meet as members of the SMS Realty Corporation, then held an executive session and adjourned about 5:15 p.m.

Earl R. Thayer
Secretary

Approved Feb. 10, 1973:
Eugene J. Nordby, MD
Chairman

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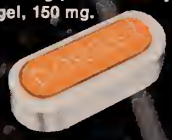

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SECTION

OPHTHALMOLOGY

MARCH 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

NEW OPHTHALMOLOGIST IN MENOMONEE FALLS

Lee Dannenberg, MD will open an office to practice ophthalmology in Menomonee Falls in July. Doctor Dannenberg attended Marquette University High School. He graduated from the University of Wisconsin School of Pharmacy in 1961. Then followed two years in the U.S. Army Medical Corps as a pharmacist. Upon discharge from service he enrolled in the University of Wisconsin–Madison Medical School, graduating in 1969. His internship was spent at St. Paul Ramsey Hospital. He presently is completing his residency in ophthalmology at Indiana University Medical Center.

OPHTHALMOLOGY RESEARCH GRANT AWARDED

The Wisconsin Society for the Prevention of Blindness, Inc. and the Medical College of Wisconsin recently announced that a research grant had been awarded to Henry F. Edelhauser, PhD, associate professor of physiology and ophthalmology, in the amount of $4,887.

This grant, approved by the National Society for the Prevention of Blindness, Inc.'s Basic and Clinical Research Committee, enables Doctor Edelhauser to investigate the effect of commonly used drugs and enzymes placed into the eye during cataract surgery on corneal transparency.

For the past six years, Doctor Edelhauser and Diane Van Horn, PhD, associate professor of physiology and ophthalmology, have been working in the area of corneal cryopreservation of corneal tissue. These studies have included the areas of corneal metabolism and structure.

ALUMNI DAY—SCIENTIFIC ABSTRACTS

The following abstracts are from papers presented at the Medical College of Wisconsin Alumni Day June 3, 1972:

Toxicity of Dimethyl Sulfoxide as a Corneal Cryoprotective Agent, by B. McCarey, MD:

These studies showed that DMSO perfused to the corneal endothelium at 4°C in concentrations used during cryopreservation are not toxic; however, these same concentrations perfused to the corneal endothelium at 34°C show a toxic effect.

Metabolic Evaluation of Cryopreserved Corneal Tissue, by D. Geroski, MD:

While the specific nature of the cornea's dehydrating mechanism has yet to be defined, it is well documented that this mechanism responsible for corneal transparency is an active process requiring energy derived from the metabolism of glucose.

In this study the data suggested that cryopreserved corneas rely more heavily on the anaerobic metabolism of glucose than does the fresh tissue. It appears that the metabolic insult of cryopreservation is due to either the freezing and/or thawing process and not the cryoprotective solutions or mechanical trauma resulting from this procedure.

Occlusion of the Canaliculi—A Surgical Approach, by Herbert Giller, MD:

Occlusion of the canaliculi can occur as a result of trauma, infection, congenital atresia, and tumors. This can be treated effectively surgically by inserting a Reinecke tube.

Frontal Sino-cutaneous Fistula—A Case Report and Review of the Literature, by Gregory P. Kwasny, MD:

A case of fistula from the frontal sinus to the upper lid as a complication of chronic frontal sinusitis is presented. A review of the ophthalmic literature was presented along with selected references from related specialties.

LOW VISION CLINIC EXPANDS

The Low Vision Clinic of the Curative Workshop of Milwaukee will now see referrals on appointment at the University Hospitals in Madison two days per month. Appointments can be made by phoning 608/262–1994 in Madison.

The Rotary Club of Milwaukee has recently given the Low Vision Clinic a television magnifying device. Mrs. Madalyn Braun, program coordinator, will demonstrate this new device at the University Hospitals Eye Clinic in Madison from 8 AM to 10 AM Saturday, March 3.

DATES TO REMEMBER

Mar. 27: Milwaukee Ophthalmological Society and State Medical Society meetings, Milwaukee. Guest speaker: Charles Iliff, MD, Baltimore, Md.; topics: "Dacryocystorhinostomy and the Surgical Management of Mucoceles Present in the Orbit" and "Surgical Approach to Ptosis."

Apr. 24: Milwaukee Ophthalmological Society meeting. Guest speaker: Phillip P. Ellis, MD, Denver, Colo.

Details of the Ophthalmology program of the State Medical Society's Annual Meeting appeared in the February issue. □

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NEWS HIGHLIGHTS

Dr. Mason Honored by UW Medical School

A longtime Sheboygan physician, Paul B. Mason, MD,* was honored by the University of Wisconsin at a meeting of the Sheboygan County Medical Society February 22.

Doctor Mason was presented the UW Medical School's Max Fox Preceptor Award for his long service to medical education. He is the fourth person to receive the award since its inception in 1969. The award honors physicians throughout the state for their efforts in developing medical preceptorship in the state.

The program, pioneered at Wisconsin over 30 years ago, allows senior medical students at Madison to spend eight weeks with a practicing physician and helps to shape their medical careers. Students accompany the local doctor on his hospital calls, observe his hospital and office practice and help the physician in some duties.

Doctor Mason was head preceptor in Sheboygan from 1942–1964 and over 130 UW medical seniors learned firsthand how medicine is practiced in a medium-sized city during that time. The University of Wisconsin Medical School preceptorship program operates in 15 Wisconsin communities. Dr. Robert M. Senty, MD is the current preceptor in charge.

Top administrative officials from the medical school and the University of Wisconsin Medical Alumni Association, which sponsors the preceptorship award, were on hand for the presentation, which was held at the Pine Hills Country Club as part of the county medical society's regular meeting.

A native of Chippewa Falls, Doctor Mason earned his MD at Northwestern University in 1932. He interned at Passavant Hospital, Chicago, and served a three-year residency at the Mayo Clinic, Rochester, Minn., before joining the Sheboygan Clinic in January 1936. The internist was president of the clinic association from 1955–1972 and it was noted in a testimonial in his honor last January that Doctor Mason had seen at least 161,573 patients during his 36 years at the clinic.

Past president of the Sheboygan County Medical Society and active in the State Medical Society, Doctor Mason was chief of staff at St. Nicholas Hospital, and a member of the state planning, peer review, and health insurance committees.

Previous recipients of the preceptorship award have been MDs Merritt L. Jones, Wausau; Peter A. R. Midelfort, Eau Claire; and Leslie G. Kindschi, Monroe.

Wood Medical Society Elects Officers

L. C. Pomainville, MD,* Wisconsin Rapids, spoke to 31 members of the Wood County Medical Society February 1 during its meeting in Marshfield. His subject was the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

The Society also elected the following officers: president—R. L. Hansen, MD,* Marshfield; vice-president—J. E. Thompson, MD,* Port Edwards; and secretary–treasurer, Francis Kruse, Jr., MD,* Marshfield.

Election of delegates and alternates to the State Medical Society's House of Delegates resulted in the following: MDs F. N. Lohrenz,* J. B. Wyman,* and R. L. Johnson,* delegates; and J. E. Thompson,* T. J. Rice,* and R. L. Hansen,* alternates.

Guests at the meeting were Glenn Waldschmidt, regional representative of the State Medical Society, and Dean Nelson, administrator of Riverview Hospital, Wisconsin Rapids.

PHYSICIAN BRIEFS

C. B. Hatleberg, MD*

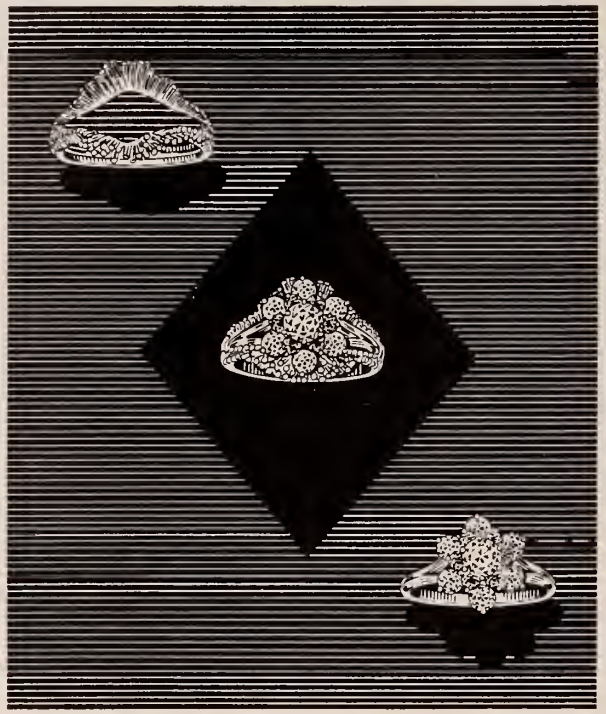
. . . Chippewa Falls in January was honored by the Chippewa County Medical Society for his 50 years of medical service to the community. The Society during its regular monthly meeting presented him with an engraved walnut plaque which simply stated: "In recognition of 50 years of medical service to the community through the art of Medicine and Surgery." Along with the plaque Doctor Hatleberg was awarded a life membership in the Medical Society. In recounting the highlights of his career, Doctor Hatleberg had organized the first staff structure for St. Joseph's Hospital and served as its president for two years. He has served as president of the Chippewa County Medical Society, president of the Tenth Councilor District of the State Medical Society, and still remains active in organizational affairs.

Dr. Hatleberg and plaque

William W. Jones, MD

. . . formerly of Fort Dodge, Ia., recently joined the medical staff of the Red Cedar Clinic in Menomonie. He graduated from the University of Iowa Medical School and completed his internship and surgical training at Latter Day Saints Hospital, Salt Lake City, Utah. He has been associated with the Kersten Clinic, Fort Dodge, Ia.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



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PHYSICIAN BRIEFS . . .

Richard J. Botham, MD*

. . . Madison, recently was named chief of staff of St. Mary's Hospital Medical Center in Madison. Other officers named were: MDs David J. Noll,* chief-elect; Timothy J. Donovan,* secretary–treasurer; and John G. Albright,* representative to Dane County Medical Society; all physicians are from Madison.

Roy E. Buck, MD*

. . . Oshkosh, recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the group's annual meeting held in Las Vegas, Nev.

Frederick G. Gaenslen, MD*

. . . Milwaukee, recently was elected president of the Easter Seal Society for Crippled Children and Adults of Milwaukee County, Inc. Doctor Gaenslen also has served as chairman of the child development committee.

Irvin M. Becker, MD*

. . . Milwaukee, recently was named chief of staff at Mount Sinai Medical Center. Doctor Becker is president-elect of the Milwaukee Society of Internal Medicine, and past president of the Milwaukee Gastroenterological Society. He has been a preceptor at the University of Wisconsin Medical School and is a clinical professor of internal medicine at the Medical College of Wisconsin. He is a member of the medical executive committee and received the first "Intern–Resident Outstanding Teacher Award" in 1970–71.

L. R. Burger, MD

. . . Berlin, recently became associated with MDs L. J. Seward* and Steve Osicka* in Berlin. He did undergraduate work at Harvard University and received his medical degree from the University of Illinois Medical School. His residency in psychiatry was taken at the University of Wisconsin Medical School. Prior to moving to Berlin, Doctor Burger had practiced in Peoria, Ill., and Beverly Hills, Calif.

Betty J. Bamforth, MD*

. . . in February was appointed assistant dean for educational administration at the University of Wisconsin–Madison Medical School. As assistant dean Doctor Bamforth will coordinate all four years of the medical school curriculum with faculty members and also serve as the student counselor. She replaces Donald R. Korst, MD* who became director of the medical school's Independent Study Program several months ago. Acting chairman of anesthesiology at Wisconsin from 1969–1971, Doctor Bamforth joined the UW medical faculty in 1954 and became a full professor 10 years later. As a practicing physician she was most closely associated with the open heart surgery program as it was developing at Wisconsin.

Leo R. Weinshel, MD*

. . . a Milwaukee surgeon and brigadier general of the 30th Hospital Center, Fort Sheridan, Ill., was awarded the Army Legion of Merit at a pre-retirement ceremony held late last year at Fort Sheridan. General Weinshel retired from the military service with over 35 years of Active and Reserve Component service Dec. 31, 1972. In addition to receiving the Legion of Merit, General Weinshel was presented special letters of recognition from the Secretary of Defense, Melvin R. Laird; the Secretary of the Army, Robert Froehlke; the Chief, Army Reserve, General J. Milnor Roberts; and letters of recognition from several Milwaukee County officials.

William A. Sannes, MD*

. . . Soldiers Grove, recently was featured in *The Kickapoo Scout* in recognition of his 40th anniversary of serving the Kickapoo Valley residents' medical needs. Although he's the only physician in the area, he has started shortening his working hours in consideration of his age and health. Doctor Sannes was born in Oslo, Norway, and came to the USA when he was 12 years old. The Sannes family settled in Madison

Dr. Sannes

where he attended the University of Wisconsin. He received his medical degree from the University of Cincinnati Medical School and served his internship at Madison General Hospital in Madison. He then started practicing medicine in Soldiers Grove. (Photo courtesy THE KICKAPOO SCOUT)

W. B. Hildebrand, MD*

. . . spoke on "New Economics of Health Care" at the January 4 meeting of the Winnebago County Medical Society in Oshkosh. Doctor Hildebrand, Menasha, is a Wisconsin delegate to the AMA. Sixty-three members attended.

Stanley N. Graven, MD*

. . . Madison, has been appointed to the National Task Force on Perinatal Care. The Task Force is charged with developing guidelines for organization of services, personnel, and finances for the delivery of perinatal care throughout the entire country. The Task Force, jointly sponsored by the AMA, American College of OB–GYN, American Academy of Pediatrics, and the American Academy of Family Physicians, is funded by the National Foundation–March of Dimes. Doctor Graven is chairman of the section on personnel for the Task Force. He is professor of pediatrics, University of

Dr. Bamforth

Dr. Weinshel

Wisconsin–Madison Medical School and director of Wisconsin Newborn Center of St. Marys Hospital Medical Center, Madison.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1973

6 Madison Urological Society
6 Madison Anesthesiology Society
6 Dane County Medical Society Board of Trustees
7 SMS Commission on Public Policy
7 Madison General Hospital Surgical Staff
9 SMS Commission on Medical Care Plans
10 Committee on Economic Medicine, Finance Committee, Executive Committee of SMS Council and SMS Council
13 Board Exams for Professional Nurses
14 Board Exams for Professional Nurses
16 Steering Committee and Task Force, Wisconsin Emergency Medical Services Program
17 SMS Division on Maternal and Child Welfare
17 Wisconsin College Health Association
17 Board of Directors, Wisconsin Health Care Review, Inc.
22 SMS Commission on Scientific Medicine
23 Wisconsin Clinic Managers
26 Madison District Nurses Association
28 SMS Commission on Health Information
28 Dane County Medical Society Committee on Foundations

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Dr. Krumbiegel Honored by Milwaukee Medical Society

Retiring City of Milwaukee Health Commissioner, Edward R. Krumbiegel, MD, was commended February 9 by the Medical Society of Milwaukee County for his 32 years of service to the residents of Milwaukee.

A resolution passed by the Society's Board of Directors was presented to Doctor Krumbiegel by Jules Levin, MD,* president of the Medical Society, at a testimonial dinner which was held by City Health Department employees.

Doctor Levin cited Doctor Krumbiegel for his inspiration and leadership in the community. "Through Doctor Krumbiegel's long-standing dedication to quality health care the problems of polio, scarlet fever, whooping cough, measles, tuberculosis and many other communicable diseases have been widely eliminated in our community."

The Medical Society also lauded Doctor Krumbiegel for assuming a leadership role in the development of numerous community programs which have included water fluoridation, lead poisoning control, food inspection, the development of municipal housing and sanitation codes, and countless other programs.

"The monumental accomplishments which can be attributed to Doctor Krumbiegel and his staff should serve as an exemplary model to the some 1,000 township health offices throughout Wisconsin to coordinate and unify their efforts," Doctor Levin noted.

"By unifying public health programs in many important areas, into county, city–county or multiple county public health departments, it might be possible for all Wisconsin residents to enjoy the type of health services which Milwaukeeans have enjoyed for the past 32 years."

Doctor Krumbiegel was appointed City Health Commissioner in 1940, making him one of the nation's youngest municipal health officers. The Medical Society strongly endorsed his appointment.

Resident Transitional Facility Established in Marshfield

A unique, home-like living facility, designed to help mentally or emotionally disadvantaged people achieve their capacity for independent living, has been established by the Marshfield Clinic Foundation.

"Transition House," as this community service project of the Foundation is called, occupies a large, two-story home near downtown Marshfield. Fifteen residents, both male and female, can be accommodated.

According to Jerry Carson, Marshfield Clinic psychiatric social worker and program director for Transition House, residents are referred to the facility by hospitals and doctors in Central and Northern Wisconsin, the Wisconsin Division of Vocational Rehabilitation, social services agencies, and in some cases, individual families.

Residents at Transition House generally are training for a job, or are looking for work but need counseling and an organized environment to enable them to move into an independent or family living situation. The average length of stay will be three to six months.

Wisconsin Neurological Society to Meet in June

Members of the Wisconsin Neurological Society will meet June 1 and 2 at the Wisconsin Center in Madison. Guest speaker will be Clark H. Millikan, MD of the Mayo Clinic. □

Donald J. Welter, MD*

. . . Shell Lake physician for 19 years, recently accepted a position with the Medical College of Georgia as an assistant professor in the Department of Family Practice.

Robert C. Miller, MD

. . . Tomahawk, has become associated with R. J. Henderson, MD* in Tomahawk. Doctor Miller graduated from the University of Wisconsin Medical School in 1964 and served his internship in Burlington, Vt. His residency was taken at University Hospitals in Madison and he spent two years as a public health officer working at an Indian hospital in South Dakota.

Stephen I. Hegedus, MD

. . . Marshfield, recently joined the staff of the Marshfield Clinic. Doctor Hegedus graduated from the University of Wisconsin Medical School in 1966 and served an internship and residency at Gorgas Hospital in the Canal Zone. He also served a residency in dermatology at the Marshfield Clinic and St. Joseph's Hospital. Prior to joining the Clinic, Doctor Hegedus completed an 18-month residency at University Hospitals in Madison.

George M. Goza, MD*

. . . recently became associated with the medical staff of the Cumberland Medical Clinic. Doctor Goza is a graduate of Emory University of Medicine in Atlanta, Ga., and also attended Yale University and the University of Minnesota. He was in private practice in Atlanta and also served with the Northern Pines Guidance Clinic in Cumberland.

Carl Zenz, MD*

. . . West Allis, recently was elected president of the American Academy of Occupational Medicine at the annual meeting held in New Orleans. Doctor Zenz also serves on the Committee on Occupational Health of the State Medical Society of Wisconsin. □

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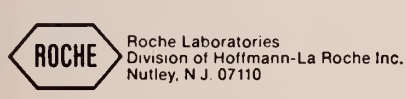

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While Valium can be a most elpful adjunct to your counseling, should be prescribed only as long excessive psychic tension persts and should be discontinued hen you decide it has accomished its therapeutic task. In eneral, when dosage guidelines e followed, Valium is well lerated (see Dosage). For conenience it is available in 2-mg, 5-mg id 10-mg tablets.

Drowsiness, fatigue and ataxia ave been the most commonly reorted side effects.

Until response is determined, atients receiving Valium should e cautioned against engaging in azardous occupations requiring omplete mental alertness, such driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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OBITUARIES

Russell A. A. Oldfield, MD, 79, Eagle River physician for over 50 years, died Dec. 11, 1972, in Eagle River.

Born on Feb. 14, 1892, in Bay City, Mich., Doctor Oldfield graduated from the University of Michigan Medical School in 1917 and served in the United States Marine Corps during World War I. He had been in practice in Eagle River since 1925. Doctor Oldfield was a member of the "50 Year Club" of the State Medical Society of Wisconsin and a member of the American Academy of Family Physicians. He was a past president of the Oneida–Vilas County Medical Society and a member of the American Medical Association.

Surviving are his widow, Ethel; and two sons, Russell A. A., Jr., Nashville, Tenn., and Carter Lee of St. Louis, Mo.

William M. Richard, MD, 91, Prentice, died Dec. 13, 1972, in Medford.

Born on March 24, 1881, in North Dakota, Doctor Richard was educated in Europe and the United States. A boxing enthusiast in his youth, he engaged extensively in the sport to further his medical education. Doctor Richard practiced in the Chicago area and retired to Prentice in 1959.

William M. Larsen, MD, 47, Madison, died Jan. 2, 1973, in Madison.

Born on Aug. 13, 1925, in Glasgow, Nova Scotia, Canada, Doctor Larsen graduated from Dalhousie University in 1954 and served his internship at Victoria General Hospital, Halifax, Nova Scotia, and his residency at Warren State Hospital, Warren, Pa. At the time of his death, he was a staff psychiatrist in the Child–Adolescent Program at Mendota State Hospital and was a consultant at the Rock County Hospital in Janesville.

Surviving are his widow, Ruth; and five sons, Carl, John, William, Blair, and Bruce, Madison.

Alfred A. Busse, MD, 88, Jefferson physician for 58 years, died Jan. 11, 1973, in Fort Atkinson.

Born on Sept. 13, 1884, in Milwaukee, Doctor Busse graduated from Marquette University School of Medicine in 1914 and had practiced in Jefferson until his death. He was a past president of the American College of Chest Physicians and served as medical director of Forest Lawn Sanatorium from 1923–1958. He also was a member of the medical staff of Fort Atkinson Memorial Hospital.

He was a member of the Jefferson County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a son, David, Park Ridge, Ill., and a daughter, Mrs. Robert (Ruth) Wright of Austin, Minn.

Carl D. Neidhold, MD, 75, Appleton, former vice president of the State Board of Health, died Jan. 12, 1973, in Appleton.

Born on May 15, 1897, in Wakefield, Mich., Doctor Neidhold graduated from Northwestern University Medical School in 1923 and served his internship at Cook County Hospital, Chicago, Ill. His residency was taken at King's County Hospital, Brooklyn, N.Y. Doctor Neidhold served in the United States Army Medical Corps during World War I.

In 1949, he was appointed to the State Board of Health and in 1957, was elected vice president of the board. Doctor Neidhold, active in the affairs of the State Medical Society of Wisconsin since 1924, served as a vice-chairman in a fund raising drive of the Society to establish a Wisconsin Medical Museum, which is now the Museum of Medical Progress and Stovall Hall of Health. In 1954, he was elected to the board of directors of Blue Cross. He was a charter member of the Wisconsin Society of Obstetricians and Gynecologists and also a corporate charter member of Blue Cross. Doctor Neidhold also was a member of the Wisconsin Heart Association, American Public Health Association, and American Association of Railway Surgeons.

He was a past president of the Outagamie County Medical Society and a member of the American Medical Association. He was scheduled to be honored into the State Medical Society's "50 Year Club" at its Annual Meeting this month (March).

Surviving are his widow, a son, and daughter.

Roger C. Cantwell, MD, 76, one of the founders of the Cantwell–Peterson Clinic, Shawano, died Jan. 18, 1973, in Shawano.

Born on July 2, 1896, in Shawano, Wis., Doctor Cantwell graduated from Rush Medical College in 1920 and served his internship and residency at Washington Boulevard Hospital in Chicago. In 1922 he joined his father, the late William Cantwell, MD, in practice in Shawano. In 1931, Doctor Cantwell along with his father and Lyndle W. Peterson, MD, established the Cantwell–Peterson Clinic and in 1932, Doctor Cantwell's brother, the late Arthur A. Cantwell, MD, joined the clinic.

Active in community affairs, Doctor Cantwell was the recipient of the Distinguished Citizens Award presented by the Shawano area Chamber of Commerce. In 1967 he was elected to the American College of Physicians and Surgeons and in 1971 he became a member of the State Medical Society's "50 Year Club." He served on the Committee on Cancer and Division on Aging of the State Medical Society of Wisconsin. He was a member of the Wisconsin Society of Internal Medicine, Wisconsin Heart Association, and Wisconsin Cancer Society.

He served as president of the Shawano County Medical Society for three terms and was a member of the American Medical Association.

Surviving are his widow, Cora; and a son, Roger, of Madison. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF FEBRUARY 9, 1973

NEW MEMBERS

Barbier, Arthur G., 815 S. 10th St., La Crosse 54601
Chang, Sekon, 2388 N. Lake Dr., Milwaukee 53211
Grogan, John P., 3237 S. 16th St., Milwaukee 53215
Harris, Irwin, 3137 Term Ct., Green Bay 54301
Haskell, David S., 10425 W. North Ave., Milwaukee 53226
Holmes, Russell E., 307-H Eagle Heights Apts., Madison 53705
Limoni, Patrick F., 601 Reed Ave., Manitowoc 54220
McGregor, William R., 8700 W. Wisconsin Ave., Milwaukee 53226
Miller, Gerald J., 4072 Terrace Dr., La Crosse 54601
Moylan, Joseph A., Jr., 1300 University Ave., Madison 53706
Sanfelippo, Michael L., D.O., 2219 E. Capitol Dr., Milwaukee 53211
Spring, Donald A., 836 N. 12th St., Milwaukee 53233
Stanhope, C. Robert, 1117 Storyglen Dr., Irving, Tex. 75062
Sy, Santiago T., 2925 W. Kilbourn Ave., Milwaukee 53208
Taylor, Thomas F., 12229 W. Dearbourn Ave., Wauwatosa 53226

CHANGE OF ADDRESS

Andrews, George R., 808—3rd St., Wausau 54401
Atamdede, Yasar I., 6501 S. 116th St., Franklin 53132
Ausman, Donald C., 735 W. Wisconsin Ave., #1190, Milwaukee 53233
Bemis, Edwin L., 1540 N. 119th St., Wauwatosa 53226
Blevins, James W., P. O. Box 68, Juneau 53039
Choe, Dong C., 101 E. Milwaukee St., Janesville 53545
Coffey, William L., Jr., 735 W. Wisconsin Ave., Milwaukee 53233
Dieterle, Carl H., 626 N. Cass St., Milwaukee 53202
Hauschild, Werner A., 6537—39th Ave., Kenosha 53140
Henschel, Ann Bardeen, 412 North Lake Dr., Oconomowoc 53066
James, John R., 409 South Barstow, Eau Claire 54701
Lulloff, Rolf S., 1277—A Elm St., Fort Dix, N. J. 08640
Mayr, James F., 225 Poplar, Apt. 7, Idaho Falls, Idaho 83401
Powondra, Philip F., 924 Oak St., Neenah 54956
Sneed, Robert J., P. O. Box 233, Ashland 54806
Strickland, Samuel A., 3101 Lorna Rd., Apt. 812, Birmingham, Ala. 35216
Talens, Antonio C., 924 Oak St., Neenah 54956
Walton, Judith D., 2821 Century Harbor Rd., Middleton 53562
Warren, Jeffrey L., 620 East Longview, Appleton 54911
Warth, Chester G., 710 North Plankinton Ave., Milwaukee 53203
Wong, James R. P., 835 South Van Buren, Green Bay 54301
Worm, George J., 7827 West Burleigh St., Milwaukee 53222

DEATHS

Oldfield, Russell A., Oneida–Vilas County, Dec. 11, 1972
Richard, William M., nonmember, Dec. 13, 1972
Haines, Marcellus C., Winnebago County, Dec. 30, 1972
Larsen, William M., nonmember, Jan. 2, 1973
Busse, Alfred A., Jefferson County, Jan. 11, 1973
Neidhold, Carl D., Outagamie County, Jan. 12, 1973
Cantwell, Roger C., Shawano County, Jan. 18, 1973
Geocaris, Konstantin, Dane County, Jan. 18, 1973 □

70-YEAR-OLD DOCTORS GET BREAK IN DUES

The State Medical Society of Wisconsin reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues-exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classification can be arranged.

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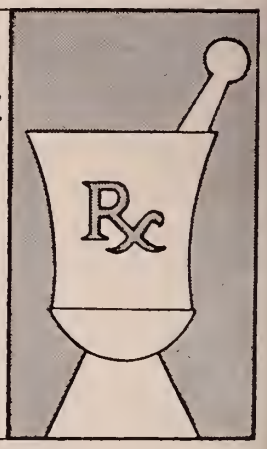

"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Are there significant differences in bioavailability and clinical predictability among drug products?

Opinion

Results of a questionnaire to 7,000 physicians:

44.6%
Agree there is a significant difference

24.9%
Believe there is no difference

30.5%
Had no opinion

Are there significant differenc in bioavailability and clinica predictability among drug product

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University

I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictabilit More Important Than P

Although the questio price has been greatly aggerated, it is true t patients can on occas save money on gene drugs. But you are not ing to dare attempt to s money if it jeopardizes patient's health. Let's turn to the example t has become very promin in recent years, that of cardiac glycosides. Tl are probably the most tc drugs we use with resp to the small difference tween a maximally effect dose and a toxic dose. Wl you are dealing with dr of this type, the first c cern must be clinical p dictability. At the risk variations in bioavaila ity, it would be sheer fc to try to save the pati what might amount maybe $10 or $20 a ye The physician cannot m age his patient unless h sure that the drug he prescribing has the sa positive effect each ti the prescription is renew This is especially sign cant when the patient ta the product, not for mont but for the rest of his lif

Maker of Medicine

C. J. Cavallito, Ph.D.
ecutive Vice President
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Growing Awareness of Potential for Nonequivalence

s experience increases
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under different condi-
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stablish specifications in
icient detail to minimize
potential for their non-
ıivalence. However,
re is general agreement
t product therapeutic
ivalence would still not
ıssured even if one could minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
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Clinical Data:
Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

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Indications: For the treatment of susceptible infections; *e.g., E. coli, D. pneumoniae.* For full list of approved indications consult labeling.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.,* renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

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MEDICAL YELLOW PAGES

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PHYSICIANS EXCHANGE

IMMEDIATE OPENING FOR AN ophthalmologist, family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write S. R. Lee, MD, President, or Russel Peterson, Clinic Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 11tfn

WANTED: GENERAL PRACTITIONER to join 3 young general practitioners in college community in southeastern Wisconsin. Two hospitals with 650 beds. Starting salary with progression to full partnership, vacation, sick leave, and profit-sharing benefits. Contact Dept. 374 in care of the Journal. 7tfn

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

WANTED: INTERNIST, BOARD certified or eligible. Beautiful northeast Wisconsin city of approximately 7000, 8-man mixed group, high standards, attractive working schedule, well equipped office. Extensive recreational facilities locally. Open salary, early partnership. Contact Dept. 387 in care of the Journal. p2–4/73

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living. DISCOVER WATERTOWN, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy-going pace of a residential city.

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Watertown, a progressive community, is ideally located equidistant between Milwaukee and Madison in southeastern Wisconsin's lake district. The community has a trade and medical practice area serving 50,000 people. Many new schools, parks, trees, social and recreational facilities. A stable economy.

Excellent rapport with the University of Wisconsin Medical School in Madison and the Medical College of Wisconsin (formerly Marquette University School of Medicine) in Milwaukee. Medical Staff leading and supporting recruitment effort. Write or call E. A. Miller, MD, Chief of Medical Staff, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel. 414/261–4210. 5tfn

MULTISPECIALTY CLINIC IN northeastern Wisconsin is expanding; group seeking allergists, general surgeon, and internist. Ultramodern 500-bed hospital located close to the clinic. Excellent recreational area. Salary first year, corporate member thereafter. Small investment second year into corporation. Young group, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 378 in care of the Journal. 9tfn

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. General Practice
3. Internal Medicine
4. Obstetrics–Gynecology
5. Orthopedics

This is an opportunity to join a 27-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 10–3

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTITIONER to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

THE OSHKOSH CLINIC IS SEEKing associates in the following areas:

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2. General Practice
3. General Surgeon
4. Internal Medicine
5. Dermatology

This is an opportunity to join a 14-man Wisconsin group located in college community of over 60,000 with excellent hospital facilities. Summer and winter recreation unlimited. For further information, contact B. Greenwood, MD, Oshkosh Clinic, Oshkosh, Wis. 54901. p1/tfn/73

WANTED EMERGENCY ROOM physician for daytime coverage, Monday through Friday. Excellent salary, one month paid vacation to join 11-man emergency room corporate group. City of 60,000 with excellent schools, living conditions, and recreation. Contact Community Emergency Services, S.C., P. O. Box 2022, Appleton, Wis. 54911. 1–3/73

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3. General Practitioner

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WANTED: INTERNIST, GP TO join expanding mixed specialty group in Green Bay. New clinic building and excellent hospital facilities. Contact R. J. Murphy, MD, Deckner Medical Center, 1751 Deckner Ave., Green Bay, Wis. Tel: 414/435–8301. p9/tfn

WILKINSON CLINIC, OCONOMOwoc, Wis., an incorporated group of 11 physicians, with various specialties and general practice represented desires, as associates, general practitioners, internists or pediatricians. Located 25 miles west of Milwaukee, surrounded by lakes, with excellent schools and recreational facilities. 110-bed accredited hospital, with full time pathologist, radiologist, physical therapy services, located 200 yards from 8 year old clinic. Call schedules adjusted with free time and coverage available. Salary open and corporate status after one year. Relocation expenses provided—profit sharing and retirement income plan. For further information please write: Business Manager, Wilkinson Clinic, Oconomowoc, Wis. 53066 or tel: 414/567–4433. 2tfn

RADIATION THERAPY RESIdency—Two positions available in July '73. Approved 3-year program designed to develop competence in clinical oncology, radiation biology, radiation physics in major modern teaching hospital. Direct applications to Director of Radiotherapy, University of Texas Medical Branch, Galveston, Tex. We are an Equal Opportunity Employer. 2–4/73

GENERAL PRACTICE. LIVE AND work in northwestern Wisconsin vacationland. Corporate general practice expanding to 8. If interested, call or write: F. M. Bannister, MD, Chetek, Wis. 54728. Tel: 715/924–4811. 3–8/73

FAMILY PRACTITIONER—MINnesota community of 2,000, 55 miles from Twin Cities, needs physician. Retirement leaves one physician in residence. Modern community owned 30-bed hospital; construction of 55-bed ECF and nursing home to begin in spring. Modern clinic. Progressive community with many young families, offering financial opportunity and the "good life." Contact James Deis, Gaylord, Minn. 55334, phone 612/237–2476 days or 612/237–2870 evenings. 3/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468–2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3–8/73

WANTED—GENERAL OR FAMILY practitioner to join 3-man group. 45-bed hospital in community. 35 miles from St. Paul. Baldwin Clinic, S.C., Baldwin, Wis. 54002. Tel: 715/684–3326. 10–5

INTERNIST OR GP: COUNTY Mental Hospital awakening to its role as comprehensive mental health center needs physician to enlarge and implement the development of a program to meet the medical care aspects of total treatment program. Modern Medicare-certified extended care facility part of complex. New 292-bed mental hospital under construction, scheduled for spring completion, includes abundant space for medical clinic. Staff membership at community general hospital encouraged. Progressive city of 50,000 gateway to Northwoods, excellent schools, outstanding parks, expressway access to Madison (45 minutes), Milwaukee (80 minutes), and Chicago (90 minutes). Excellent opportunity to meet challenge at your own pace with minimum of pressure. Salary $27,000, liberal fringe benefits. Administrator, Rock County Hospital, Box 351, Janesville, Wis. 53545. 2tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

WANTED: GENERAL PRACTItioner, preferably with surgical and obstetrical experience. Ready made practice. No investment. Senior partner retiring. Junior partner desires associate. Ideal midwest college town for family. All educational, recreational, religious, medical and dental facilities readily available in community. Contact Dept. 370 in care of the Journal. 5tfn

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

WANTED: FAMILY PHYSICIAN—eight man mixed group northeast Wisconsin, small city in fertile fishing, hunting, outdoor recreational area, lake and river. Very attractive facilities and call schedule, 84-bed municipal hospital. Open salary, early partnership. Contact Dept. 386 in care of the Journal. p2–4/73

IMMEDIATE OPENING FOR INternist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

PHYSICIAN POSITION AVAILAble: Student Health Center, University of Wisconsin–La Crosse. Excellent physical plant with attached Department of Physical Therapy and certified laboratory. Competitive salary with adequate vacation time and fringe benefits. Equal opportunity employer. Phone, visit or write: Lou R. Schmidt, MD, Student Health Center, University of Wisconsin-La Crosse, La Crosse, Wis. 54601. Tel: 608/785–1800, Ext, 226 or 274. 1–3/73

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545. tel: 1–608/752–7811. 4tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

GENERAL PRACTITIONER WITH strong interest or background in industrial medicine needed by eleven-man multispecialty clinic. Full time or part time. Salary negotiable, many fringe benefits. Asssociate status possible after one full calendar year. Contact: Administrator Medical–Surgical Clinic, S. C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215. 2–5/73

E. R. PHYSICIAN TO JOIN GROUP in moderately active emergency room Milwaukee suburb. $36,000 per year plus fringe benefits. 42-hour week. Equal share of nights and weekends. Inquiries confidential. Contact Dept. 385 in care of the Journal. 2–3/73

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial–agricultural community with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693–3021. This ad endorsed by present doctor. 2–7/73

CAN A YOUNG FAMILY PRACTItioner find: medical, social and economic happiness in "THE NORTH WOODS"? Soap Opera? Not quite! It's all here in Eau Claire, Wis. We're all GPs and we'll be moving in a new office. Don't blame us if you get here too late! Write: G. G. Giffen, MD, Putnam Heights Clinic, P.O. Box 970, Eau Claire, Wis. 54701. 2–6/73

WANTED: FAMILY PRACTITIONERS and internists to join 20-man mixed specialty clinic. Teaching opportunities guaranteed. Salary with corporate ownership in two years. William Rock, MD, East Madison Clinic, 1912 Atwood Ave., Madison, Wis. 53704. 6–5

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

WANTED: DOCTOR (SEMI-retired) interested in part time work assisting group in gynecological work in Milwaukee area hospital. Must be licensed in State of Wisconsin. Contact Dept. 389 in care of the Journal. 3–5/73

THE MARSHFIELD CLINIC IS seeking additional specialists in many areas. This opportunity combines a busy, stimulating referral practice plus an active local practice with an opportunity for family medicine. We provide excellent salary and fringe benefits as well as opportunities for research and teaching. Excellent retirement program and insurance plan. Modern 7-story office building with all diagnostic facilities available. Excellent 400-bed hospital. We are looking for physicians in the following specialties:

1. Internal Medicine
2. Orthopedic Surgery
3. Rheumatology
4. Family Medicine
5. Plastic Surgery
6. Child Psychiatry
7. General Surgery
8. Ophthalmology
9. General Practice
10. Pulmonary Disease

For further information, please contact Russell F. Lewis, MD, Medical Director, Marshfield Clinic, Marshfield, Wis. 11, 1, 3, 5

PRACTICES FOR SALE: ATHENS General Practice in modern professional building. Grossing $85,000, netting $60,000. Can be purchased on a lease arrangement with no money down. Wonderful opportunity. MILWAUKEE general family practice. Grossing $90,000 on 4 day week. Much greater potential. Attractive medical building included in this sale. Excellent opportunity for group or individual. MILWAUKEE general family and industrial practice. Ideally located in residential–industrial area. Realistically priced. OTHER EXCELLENT PRACTICES available throughout Wisconsin, Illinois and Indiana. No fee to buyers. Financing available. Strictly confidential. Free brochure. PROFESSIONAL PRACTICE SALES, 540 Frontage Rd., Northfield, Ill. 60093. Tel: 312/441–6111. 3/73

THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine—multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Neurology
2. Orthopedic surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Emergency Room

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 1–3/73

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living; discover Watertown, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy going pace of a residential city.

We urgently need family practitioners, internists and other specialties; exceptional opportunities for private or group practice growth.

Our new community health care center with its beautiful 110-bed general hospital, connecting (but separate) 24 unit medical–dental office building and connecting 120-bed nursing home, was completed in 1971.

Watertown is a progressive community, ideally located equi-distant between Milwaukee and Madison in southeastern Wisconsin's lake district; the community has a trade and medical practice area serving 40,000 people; many new schools, parks, trees, social and recreational facilities; a stable economy.

Enjoy the best of two worlds: practice in a tree-shaded medium size city with access to the medical centers at the University of Wisconsin and the Medical College of Wisconsin (formerly Marquette University School of Medicine). The medical staff is leading and supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261–4210. 3tfn/73

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

GENERAL PRACTITIONER wanted to share the good life in beautiful KEWAUNEE, Wis. We can offer you, an accredited hospital, office and clinic space, crime free community, good schools, three fine churches, beautiful homes, beautiful people, Lake Michigan with its fabulous trout fishing, water skiing, boating, snowmobiling, skiing, golfing and the PACKERS. Packer Country is just 25 miles west and lastly—MONEY. Per capita income is high. We see our doctor and we pay our bills. Write to: Doctor Search Committee, P. O. Box 222, Kewaunee, Wis. 54216. 3tfn/73

DEATH OF PHYSICIAN; WELL established general surgeon's practice of 20 years. SE Wisconsin community close to Madison–Milwaukee; 145-bed hospital; good schools; excellent for outdoor activities; modern, completely equipped office. Contact Dept. 390 in care of the Journal. g3/73

COMMERCIAL

GENERAL PRACTICE FOR SALE: South Central Wisconsin city of 6500, drawing area of 17,000. Thirty years established practice. $65,000 to $70,000 gross income . . . net $40,000 to $45,000. Excellent hospital facilities. Fully equipped office . . . competent secretary–receptionist and nurse. Contact A. J. Harris, MD, 112 W. Oak St., Sparta, Wis. 54656. Tel: 608/269–3115. 3tfn/73

FOR LEASE. SHEBOYGAN, WIS. Suite, at present occupied by oral surgeon. Available May 1, probably earlier. Other occupants are a physician and dentist. Suitable for any medical or dental specialty. Later purchase of building possible. For details write to Dept. 383 in care of the Journal. 1tfn/73

FOR SALE: BY ILLNESS DISabled physician and surgeon, as a complete unit for clinic or other MDs. Appraised by expert in new and used equipment, at minimum appraisal. All office furniture is of hand finished and rubbed, light walnut. Items: 2 exam and treatment tables, 2 stools, 1 instrument cabinet, 1 treatment stand, 1 exam chair, 1 treatment cabinet with drawers and doors (must be seen to appreciate), 1 sterilizer, 2 head lamps, 1 National procto set, transformer for lights and cautery to accommodate other instruments; 1 Raytheon microtherm, 1 Micro hematocrit, 1 centrifuge, many useful instruments, 1 baby scale, 1 adult scale, 1 Luxo floor light, 1 Miller electro unit, 1 Welch Allen oto & ophthalmoscope, 4 ear syringes—different abilities, 1 General Electric E.C.G. button type, 1 Kidde dry ice, plus sundries useful to the practice of medicine. Below the appraised evaluation, I will take $1500.00 firm. X-ray separate from above articles, 1 General Electric diagnostic table model 39, hand manipulated with all necessary accessories, speed screens, paper holders, some fresh film, hangers, stainless steel tank, etc. $500.00 firm. Call, write, or see: Glenn R. Stauff, MD, 2323 S. Webster Ave., Green Bay, Wis. 54301. Tel: 414/437–3890. 9tfn

FOR SALE: MEDICAL BUILDING. 2100 square feet. Two divided suites. Separate, central gas heat and air conditioning. Paved parking lot. Excellent location. Residential area. Five minutes from either hospital. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634-6833. 3tfn/73

ALL PROGRESSIVE MEDICAL group practices, whether proposed, recently established or established. Is your facility providing complete medical services, including professional pharmaceutical services? If not, consider the complete service you can provide with a pharmaceutical center included in your facility. Let me explain the advantages a clinically orientated pharmacist can offer you and to your patients. I am young with experience and have the ideas and ambition and want only the opportunity to implement them with a receptive group. Contact Dept. 388 in care of the Journal. 3/73

LARGE PRACTICE AVAILABLE (for sale or rental arrangements) in Ripon, an attractive and comfortable little city. Recently deceased physician's office only three years old—specifically built for two or three doctors. His widow and partner, A. C. Bachus, MD, are very anxious to obtain another physician. Community very anxious, too. Rental arrangements considered reasonable. Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748-3636. g10tfn

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

FOR SALE: PROFEXRAY MAchine. Model TS 2, maximum—KVP 100, MA—10. Contact Mrs. B. J. Haines, Cadott, Wis. 54727. g5tfn

PUBLICATIONS

Transport of High-Risk Newborn Infants. Manual published by the Canadian Paediatric Society. Suggested for use in the nursery of every hospital that delivers newborn infants and for wide circulation among physicians, nurses, ambulance drivers, hospital administrators, and community planners who are interested in providing the best of care for sick infants. Indexed; references, 198 pages. Price, $5.00 each (Canadian funds). Orders to: Dr. Victor Marchessault, Executive Secretary, Canadian Paediatric Society, % Department of Paediatrics, Centre Hospitalier Universitaire, University of Sherbrooke, Sherbrooke, P.Q., Canada.

1972 Recommended Employment Standards for Registered Professional Nurses. Approved by the membership of Wisconsin Nurses Association at its annual meeting in October 1972. Copies available from Mrs. Alice A. Weldy, RN, Executive Administrator, WNA, Inc., 161 West Wisconsin Ave., Milwaukee 53203.

Dealing with the Crisis of Suicide. A new Public Affairs Pamphlet, by Calvin J. Frederick and Louise Lague. Authors explore the taboos, tragedies, and statistics of suicide. Authors also consider some of the special problems of suicide among Spanish-surnamed persons and among young people, for whom suicide is now the fourth leading cause of death. This pamphlet, No. 406A in the Public Affairs Pamphlet series, is available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, NY 10016.

ANNOUNCEMENTS

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20-21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

Under CHAMPUS successive inpatient admissions for similarly recurring procedures or for treatment of the same condition will be considered as one admission for the purpose of computing the CHAMPUS beneficiary's share of the charges, provided not more than 30 days elapse between the successive admissions.

NATIONAL CLEARINGHOUSE FOR ALCOHOL INFORMATION (NCALI)—newly created operation within the Office of Public Affairs, National Institute on Alcohol Abuse and Alcoholism (NIAAA). NIAAA is a component of the National Institute of Mental Health in HEW's Health Services and Mental Administration. The Clearinghouse will provide for the first time a national focal point for the collection and dissemination of information on the subjects of alcohol and alcohol abuse to a wide range of audiences, including physicians, researchers, counselors, alcoholic people and their families, and the general public. Among the many services provided by the Clearinghouse will be: gathering comprehensive alcohol information; replying to public inquiries and requests; establishing a library; using computer systems; providing references services; distributing documents; publishing NCALI Bulletin and a quarterly newsletter; developing new materials; and compiling directories of alcoholism programs and federally supported activities in this area. The Clearinghouse will emphasize nationwide service to the user—any individual or organization that makes an inquiry to the Institute or to the Clearinghouse. The address and phone number are: National Clearinghouse for Alcohol Information Annex, P.O. Box 1156, Rockville, Md. 20850; phone: 301/948-4450.

SOCIAL SECURITY beneficiaries are reminded that April 16, 1973 is the deadline for filing annual reports of earnings for 1972.

FILMS

Psychiatric Emergencies . . . therapy, discharge, aftercare. A medical educational film produced by Sandoz Pharmaceuticals, East Hanover, N.J. Ronald C. Smith, MD, Associate Clinical Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif., consultant. A 17-minute film about three patients at the Brea Hospital Neuropsychiatric Center, Brea, Calif., admitted in states of psychiatric emergency typical of most admissions from the community in institutions of this kind. Purpose of film is to demonstrate how an emergency psychiatric service can be effectively implemented in a general hospital or mental health delivery center with a minimal professional staff. Film stresses that comprehensive management of the psychiatric emergency can be one of the most important factors in preventing future relapses and therapeutic failures.

Thyroid Disease as a Late Sequela of Radioactive Fallout is the title of a new film from the Flint Laboratories division of Baxter Laboratories, Inc. The 30-minute, full color-sound film was produced by Flint in conjunction with Brookhaven National Laboratory and the Atomic Energy Commission. It specifically covers the subject of thyroid disorders as related to accidental fallout of radioactive iodine on the people of Rongelap Island in 1954. The film has won the Gold Camera, Cine, and New York Film Festival awards. Booking arrangements may be made through: Professional Services Department, Flint Laboratories, 200 Wilmot Road, Deerfield, Ill. 60015.

The Heritage of Operating Room D. A new, full-color motion picture which interweaves the history of surgery, anesthesiology and anatomy around a present-day open heart operation has been produced for Parke, Davis & Company, a subsidiary of Warner-Lambert Company. The 27½-minute film tells the story of three-year-old Lynda's successful surgery in which a hole in the heart area is repaired with a Teflon patch. Narrated by stage and screen star Jose Ferrer, the drama is played out in the present, but "peopled" with characters from the past whose medical triumphs made possible Lynda's operation.

Through live and computerized animation stand photography, the viewer sees the historical development of the conquest of pain, of anesthesia, of antiseptic cleanliness, and of surgical skill from the dawn of civilization to the present.

The film also uses 14 of the Parke-Davis Great Moments in Medicine oil paintings to help tell the story of medical discoveries and historical development. "The Heritage of Operating Room D," available through Modern Talking Pictures, was produced by Medical Vistas, and written and directed by Al Wasserman, of New York.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Mar. 24: Annual Banquet, Marquette–MCW Medical Alumni Association, Milwaukee Athletic Club, Milwaukee. Reservations: M-MCW Medical Alumni Assoc., 561 N. 15th St., Milwaukee 53233; tel. 414/272–5450, ext. 250.

Mar. 24: Fifth Annual Southeastern Wisconsin Cancer Conference—"Earlier Cancer Detection," Pfister Hotel, Milwaukee.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Mar. 26–27: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

Mar. 27: Spring Meeting, Wisconsin Surgical Society, Milwaukee.

Mar. 29–31: Midwest Regional Medical Symposium (Exercise and The Heart) and Physical Fitness Clinic, at University of Wisconsin–La Crosse. Info: Dr. Clifton De Voll, Assoc. Dean of HPER, UW—La Crosse, La Crosse 54601.

Mar. 30–31: Respiratory Care Symposium, cosponsored by St. Francis, St. Luke's, and St. Mary's hospitals, Milwaukee, at The Ramada Inn, 11811 West Blue Mound Road, Milwaukee.

Apr.: Spring Meeting, North Central Wisconsin Orthopedic Society, Wausau. Info: Thomas O. Miller, MD, President, 630 First St., Wausau 54401.

Apr. 4: "The Encounter Process—Expectations and Limitations," symposium sponsored by the Milwaukee Sanitarium Foundation, Inc. at the Marc Plaza Hotel in Milwaukee.

Apr. 11: Family Practice Conference, Neenah.

Apr. 12: Family Practice Conference, Wausau.

Apr. 18: Family Practice Conference, Eau Claire.

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May: Annual Meeting, Wisconsin Clinic Managers. (Note that this will not be held in conjunction with the Annual Meeting of the State Medical Society as in past years.)

May 4: Spring Conference, Wisconsin Association of Alcohol and Other Drug Abuse, Howard Johnson Motel, Fond du Lac.

May 5: Neurology and Neurosurgery Course for Family Practitioners and Other Specialists, sponsored by the Department of Neurosurgery through the Division for Health Professions Education of the Medical College of Wisconsin, at the Marriott Inn, Brookfield.

May 9: Family Practice Conference, Neenah.

May 9: Spring Refresher Seminar of the Wisconsin Academy of Family Physicians, St. Vincent's Hospital, Green Bay.

May 10: Family Practice Conference, Wausau.

May 11–12: University of Wisconsin Alumni Weekend, Madison.

May 16: Family Practice Conference, Eau Claire.

May 21–22: Workshop for occupational therapists and other professionals interested in learning disabilities and sensorimotor dysfunctions in children, Madison. Sponsored by the Wisconsin Committee for Continuing Education in Sensory Integration in collaboration with the Center for the Study of Sensory Integrative Dysfunction, Pasadena, Calif.

May 30–31: Symposium on Peptide Synthesis, at The Wisconsin Center on the University of Wisconsin–Madison Campus, Madison. Info: Theo Gerritsen, DSc, Postgraduate Medical Education, WARF Bldg., 610 Walnut St., Madison 53706.

June 13–14: Annual Meeting, Wisconsin Regional Medical Program, Pioneer Inn, Oshkosh.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

1973 NEIGHBORING STATES

Apr. 6–7: Seminar on "The Role of the Medical Director in the Long-Term Care Facility," O'Hare Inn, Chicago.

Apr. 16–18: Third Annual Great Lakes Health Congress, McCormick Place-on-the-Lake, Chicago, Ill.

Apr. 29–30: Congress on Environmental Health, Ambassador West Hotel, Chicago.

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

May 9–12: Seventeenth Postgraduate Course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, Sheraton–Chicago Hotel, Chicago, Ill.

May 24–25: Minnesota State Medical Association Annual Meeting, Raddison South, Minneapolis.

June 10–15: 1973—Midwest Institute on Alcoholism, Western Michgian University, Kalamazoo, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Apr. 1–4: First Annual Four-Day Spring Meeting, American College of Surgeons, Americana and Hilton Hotels, New York.

Apr. 11–13: Annual Meeting and National Conference, National Society for the Prevention of Blindness, Inc., at Hotel Roosevelt, New York City.

Apr. 16–19: American Industrial Health Conference, Currigan Hall, Denver, Colo. Info: Industrial Health Conference, 150 North Wacker Drive, Chicago, Ill. 60606.

Apr. 17–18: Obstetric and Gynecologic Endoscopy, at Cleveland, Ohio. Info: Amir H. Ansari, MD, Dept of Ob–Gyn, St. Luke's Hospital, Cleveland, Ohio 44104.

Apr. 22–28: International Symposium on Oxygen Transport to Tissue, Medical University of South Carolina, Charleston, S.C., and Clemson University, Clemson, S.C.

Apr. 25–26: Peripheral Vascular Disease course, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Apr. 26–28: Fourth National Congress on Medical Ethics, Washington Hilton, Washington, D.C.

May 4–5: Annual Conference, British Columbia Oto-Ophthalmological Society, Hotel Vancouver, Vancouver, B.C.

May 16–18: Advances in Pediatric Radiology, Emerson Auditorium, Indiana U, Indianapolis.

May 20–25: Hospital Medical Staff Conference, Sun Valley, Idaho. Info: Northwest Hospitals Education and Research Alliance, % Oregon Association of Hospitals, 220 S.W. Morrison St., Portland, Ore. 97204; tel. 503/228–5608.

May 20–26: American Gastroenterological Association postgraduate course, *Cirrhosis and Portal Hypertension* as part of Digestive Disease Week. Americana Hotel, New York. Info: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N. J. 08086.

May 21–24: Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Bal Harbour, Fla.

MEDICAL MEETINGS . . .

May 29–31: Postgraduate seminar *Master Interpretation of Clinical Electrophysiology* sponsored by University of Miami School of Medicine and Council on Clinical Cardiology of the American Heart Association. Contemporary Hotel at Disney World, Lake Buena Vista, Fla. Info: Dr. Louis Lemberg, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

June 11–16: General Practice Review, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

June 14: Eighth Annual Continuation Course on "Clinical Electroencephalography," Statler–Hilton Hotel, Boston, Mass. Info: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55901.

June 15–16: Annual Meeting, American Electroencephalographic Society, Statler–Hilton Hotel, Boston, Mass. Info: Mrs. Margaret H. Henry, Exec. Secy., American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

June 21–23: Postgraduate Course on Newborn Problems, Disney World, Lake Buena Vista, Fla. Sponsored by the American Academy of Pediatrics and presented by the U of Florida, College of Medicine.

July 16–20: Internal Medicine, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

July 29–Aug. 1: Pediatrics, U of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Sept. 19–22: District V, American College of Ob–Gyn, Pantland Hotel, Grand Rapids, Mich.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

Mar. 29–30: 26th National Conference on Rural Health, Statler Hilton Hotel, Dallas.

Apr. 6–7: 19th Annual Conference of State Mental Health Representatives, Drake Hotel, Chicago.

Apr. 13–14: 7th National Congress on the Socio-Economics of Health Care, Marriott Motor Hotel, Chicago.

Apr. 26–28: 4th National Congress on Medical Ethics, Washington–Hilton Hotel, Washington, D.C.

Apr. 30–May 1: Congress on Environmental and Public Health, Drake Hotel, Chicago.

June 24–28: Annual Convention, New York.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

1974 NEIGHBORING

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

Oct, 21–25: Clinical Congress, American College of Surgeons, Miami Beach, Fla.

* * *

Respiratory Care Symposium, March 30–31 at The Ramada Inn, 11811 West Blue Mound Road, Milwaukee. Designed to update physicians in several selected fields of respiratory care. The "for clinicians only" symposium will provide a pulmonary function overview and will place special emphasis on new developments, pulmonary problems in surgery, pulmonary rehabilitation and care of the cardiac cripple. Program should be of interest to family physicians, internists, and surgeons. Sponsored by St. Francis, St. Luke's, and St. Mary's hospitals, Milwaukee; American College of Chest Physicians, Northlands Chapter; Wisconsin Thoracic Society; and Pfizer Laboratories, Inc. Symposium also will represent annual meeting of the Northlands Chapter of the ACCP. Approved for seven hours of prescribed credit by American Academy of Family Physicians.

Family Physician Spring Refresher Seminars, St. Vincent's Hospital, Green Bay, Wednesday, May 9. Meeting acceptable for seven hours of prescribed credit by American Academy of Family Physicians. Open to all physicians. Seminars begin at 9:00 a.m. and conclude at 5:00 p.m. Luncheon for all participants at noon. Info: Wisconsin Academy of Family Physicians, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

Neurology and Neurosurgery Course for Family Practitioners and Other Specialists. One-day symposium, Saturday May 5, at the Marriott Inn, Brookfield. Designed to sharpen the neurological skills of family practitioners and other specialists. Offered by the Department of Neurosurgery through the Division for Health Professions Education of the Medical College of Wisconsin.

Dr. William S. Fields, chairman of the department of neurology, University of Texas, has been invited to participate in the program along with MCW neurologists, neurosurgeons, and related specialists.

Some of the topic sessions to be covered include streamlined neurological examination, stroke management, early management of spine injuries, drug therapy of epilepsy and meningitis, electro stimulation of pain relief, automated patient monitoring and extracranial vascular occlusion disease. Problems presented by family practitioners also will be discussed.

Course is approved by the American Academy of Family Physicians for six credits.

Further info: Department of Neurosurgery, The Medical College of Wisconsin, 8700 West Wisconsin Avenue, Milwaukee, 53226 (Tel. 414/258–2040, ext. 2338) or the Division for Health Professions Education, The Medical College of Wisconsin, 561 North 15th St., Milwaukee, 53233 (Tel: 414/272–5450, ext. 320).

The Encounter Process—Expectations and Limitations is the theme of the symposium to be sponsored by the Milwaukee Sanitarium Foundation, Inc. on April 4 at the Marc Plaza Hotel.

Papers will be presented by Dr. Irvin D. Yalom, who is an Associate Professor of Psychiatry at the Stanford University School of Medicine, Palo Alto, Calif., and Erving Polster, PhD, a clinical psychologist who is a former Chairman and presently a faculty member of the Gestalt Institute of Cleveland.

Two discussants will comment on the remarks of Dr. Yalom and Dr. Polster. They are Dr. Ervin Teplin, a Milwaukee psychiatrist who has had considerable experience in group therapy, and Richard C. Olney, PhD, also of Milwaukee, who is a consultant and field representative for the Cambridge House, where group therapy sessions are held.

The Milwaukee Sanitarium Foundation, Inc., 1220 Dewey Avenue, Wauwatosa, a nonprofit organization, operates Milwaukee Psychiatric Hospital, the Milwaukee Sanitarium, Dewey Center, and Kradwell High School.

Third Annual Great Lakes Conference. Comprehensive educational program of the major issues as well as solutions in the health care field, extending from

anesthesia to special care units, will be included. To be held April 16–18 in McCormick Place-on-the-Lake, Chicago, Ill.

The keynote address at the opening session will be presented by Frank Reynolds, award-winning television news reporter who is the anchorman for the American Broadcasting Corporation network. Mr. Reynolds will discuss the impact of the various national health insurance proposals on the American society.

The three-day Congress is sponsored by three major organizations in the health services field including the Tri-State Hospital Assembly which is devoted to hospital care in Illinois, Indiana, Michigan and Wisconsin; the Mid-America Assembly, representing nursing homes in 10 midwestern states, and the Health Industries Association, representing companies that manufacture and sell equipment used by hospitals and nursing homes.

Congress program will be devoted to providing the participants with a comprehensive and in-depth series of seminars and conferences in the field of health care, covering both hospitals and nursing homes.

Postgraduate Course on Fractures and Other Trauma. Dr. Rocco A. Calandruccio, Associate Professor of Orthopaedic Surgery, University of Tennessee; Campbell Clinic, Memphis, Tennessee, will be the distinguished guest speaker for the Course to be presented May 9–12, at the Sheraton–Chicago Hotel, 505 North Michigan Avenue, Chicago, Ill., by the Chicago Committee on Trauma of the American College of Surgeons. Dr. Calandruccio will speak on pathophysiology of non-union, fractures of the femoral hip, posterior dislocation of the shoulder, and lesions confused with lumbar discs.

Other featured guest speakers include James W. Harkess, MD, Louisville, Ky.; Kenneth G. Jones, MD, Little Rock, Ark.; Harold E. Kleinert, MD, Louisville, Ky.; and Arthur W. Trott, MD, Boston, Mass. In particular, subjects covered by the above teachers will include complications following cast application, management of pathological fractures in childhood, the unstable knee, fractures of the tibial plateau, fractures about the elbow, flexor tendon surgery, recent advances in hand surgery, growth disturbances following epiphyseal fracture, and fractures of the hip in children.

Many other types of fractures and dislocations in children and adults will be covered, as well as facial fractures from vehicular accidents, chest injuries, blunt and penetrating injuries of the abdomen, injuries to the genito–urinary tract, vascular injuries, and primary and secondary skin coverage techniques. There will be a question-and-answer period after each presentation.

Friday afternoon will be devoted entirely to the hand, with Dr. John Bell, President of the American Society of Hand Surgery, presiding.

Altogether, 36 men comprise the faculty, representing many of the medical schools in the Chicago area. The program is intended for all who care for injured patients, and is acceptable for 28½ elective hours by the American Academy of Family Physicians.

One evening session will coincide with the monthly hospital meeting of the Chicago Committee on Trauma, and will be held at the Wesley Memorial Hospital, featuring problem cases and patient management. A joint meeting with the Chicago Orthopaedic Society is scheduled for another evening.

Registration fee is $140.00, making check payable to the American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611. For interns, residents, and allied health personnel registration fee is $35.00. Included in this fee are three luncheons, and a Chairman's reception, to which spouses also are invited.

International Symposium on Oxygen Transport to Tissue. Medical University of South Carolina and Clemson University will host symposium on April 22–28. More than 160 leading scientists from the United States, Europe, and Japan will be attending the meeting. Significant information will be offered describing both the basic mechanisms of diseases and the application of recently developed instruments and drugs to the immediate treatment of such diseases as stroke and heart attacks, and several major complications of diabetes. Info: Medical University of South Carolina, 80 Barre St., Charleston, SC 29401.

Annual Assembly, World Medical Association. Oct. 14–20, Munich, Germany, just prior to the World Conference on the Human Environment, in Primosten, Yugoslavia. Includes 100th Anniversary of the Bundesaerztekammer—the German Medical Association. Includes two-day session on the computer in medicine and the confidentiality of information between patient and physician. Info: WMA, 10 Columbus Circle, New York, NY 10019.

World Medical Association, made up of 58 national medical associations, sets ethical standards for the private practice of medicine worldwide and has sponsored four international conferences on medical education. Physicians interested in associate membership ($15 a year) can apply to WMA.

Life-Saving Measures for the Critically Injured (sixteen seminar programs to provide continuing education for non-specialist physicians) will be sponsored in 16 different cities throughout the United States in 1973 and 1974 by the American College of Surgeons' Committee on Trauma in cooperation with departments of surgery of medical schools.

Seminar curriculum is divided into three broad areas: (1) Assessment of the critically injured and causes of death soon after injury—airway and respiratory problems, hemorrhagic shock, and brain damage. (2) Life-threatening injuries to the head, chest, abdomen and extremities. (3) Late life-threatening complications, including pulmonary insufficiency from non-thoracic trauma, impaired kidney function complicating patient management and complications following blood transfusions. Hyperalimentation and intensive care of the trauma patient also will be covered.

Seminar sites will be dispersed throughout the country to make one or more seminars easily accessible to all U.S. physicians.

The seminars will be credited by the AMA toward the Physicians Recognition Award, and by the American College of Emergency Physicians for continuing education requirements for its members.

Detailed announcements showing registration fees, advance registration forms, and housing information are available from the Trauma Division, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

National Energy Congress. "Energy, the Environment and Human Health" will be the theme of the Congress on Environmental Health of the American Medical Association April 29–30 in Chicago (Ambassador West Hotel).

Speakers drawn from the fields of law, federal and state government, private foundations, architecture, the universities, private industry and industrial trade associations will discuss the problems of energy production as they relate to environment and human health during the two-day Congress. It will be conducted by the Council on Environmental, Occupational, and Public Health of the AMA.

Registration fee for the Congress will be $50. This will include two luncheons and a packet of the papers presented by the speakers. Physicians attending may receive credits for continuing education. Further information is available through Diane Dale of the Department of Environmental, Public, and Occupational Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

The Wisconsin Committee for Continuing Education in Sensory Integration is sponsoring a two-day workshop on May 21–22 for occupational therapists and other professionals interested in learning disabilities and sensorimotor dysfunctions in children. The workshop is being planned in collaboration with the Center for the Study of Sensory Integrative Dysfunction, Pasadena, California and will be held in Madison. Guest lecturer will be A. Jean Ayres, PhD, who will speak on the topic "Sensory Integrative Dysfunction: Theory and Treatment." A fee of $35.00 will be charged for the workshop. Application forms are available from: Mrs. Rita Hohlstein, OTR, Route #2, Box 39-A, Waunakee, WI 53597.

Two hundred applicants will be accepted from federal area 5 (Wisconsin, Iowa, Illinois, Minnesota, Michigan, Indiana, and Missouri) on a first-come first-served basis. No applications will be processed after March 30. □

Members of the State Medical Society of Wisconsin are invited to attend the many interesting scientific presentations and exhibits scheduled for the

1973 ANNUAL MEETING
of the
Wisconsin Dental Association

Meetings will be held Monday, May 7, through Wednesday, May 9, at the Milwaukee Auditorium. A physician's 1973 membership card will permit him to register. To register, use the Kilbourn Avenue entrance between the Auditorium and Arena.

CONTRIBUTIONS—CES FOUNDATION

January 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1973:

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Dr. and Mrs. Wallace G. Irwin—*Raymond B. Dryer, MD* □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Dermal Pathology. Edited by James H. Graham, MD, Waine C. Johnson, MD, and Elson B. Helwig, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1972. 840 pages. Price: $45.00

Instructional Course Lectures. By American Academy of Orthopaedic Surgeons. Vol. XXI. The C. V. Mosby Co., St. Louis, Mo. 1972. 331 pages. Price: $22.50

Is My Baby All Right? By Virginia Apgar, MD and Joan Beck. 1973. Trident Press, A Division of Simon & Schuster, Inc., Publishers, Rockefeller Center, 630 Fifth Ave., New York City 10020. 492 pages. Price: $9.95

The Case for American Medicine. By Harry Schwartz. David McKay Company, Inc., 750 Third Ave., New York, N.Y. 1972. 240 pages. Price: $6.95

BOOK REVIEWS

Archives of Internal Medicine Symposia.

Vol. 9. Symposium on Pollution and Lung Biochemistry, guest editor, Daniel B. Menzel, PhD. American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610. 1971. 279 pages. Price: $3.50.

This book contains excellent, unique, up-to-date information on current fundamental research on the lung. For the busy non-pulmonary specialist a perusal of the articles' titles, abstracts, and Menzel's prospective and conclusions may suffice for broad information since this symposium fulfills the aspirations of the organizers: accelerate and consolidate knowledge on the lung.

It is my impression that the articles tend to answer more the basic biological problems than to explore the more clinically applied subjects. Therefore, this symposium is strong on basic biological knowledge on the lung and on experimental pollution.

A minor conceptual disagreement with Menzel's statement that the lung is composed of membrane poor cells may refer to the electron microscope structure of the cytoplasm of the cells but not to the molecular architecture needed to fulfill surfactant properties and synthesis which must be intimately linked or form membranous systems.—ENRIQUE VALDIVIA, MD □

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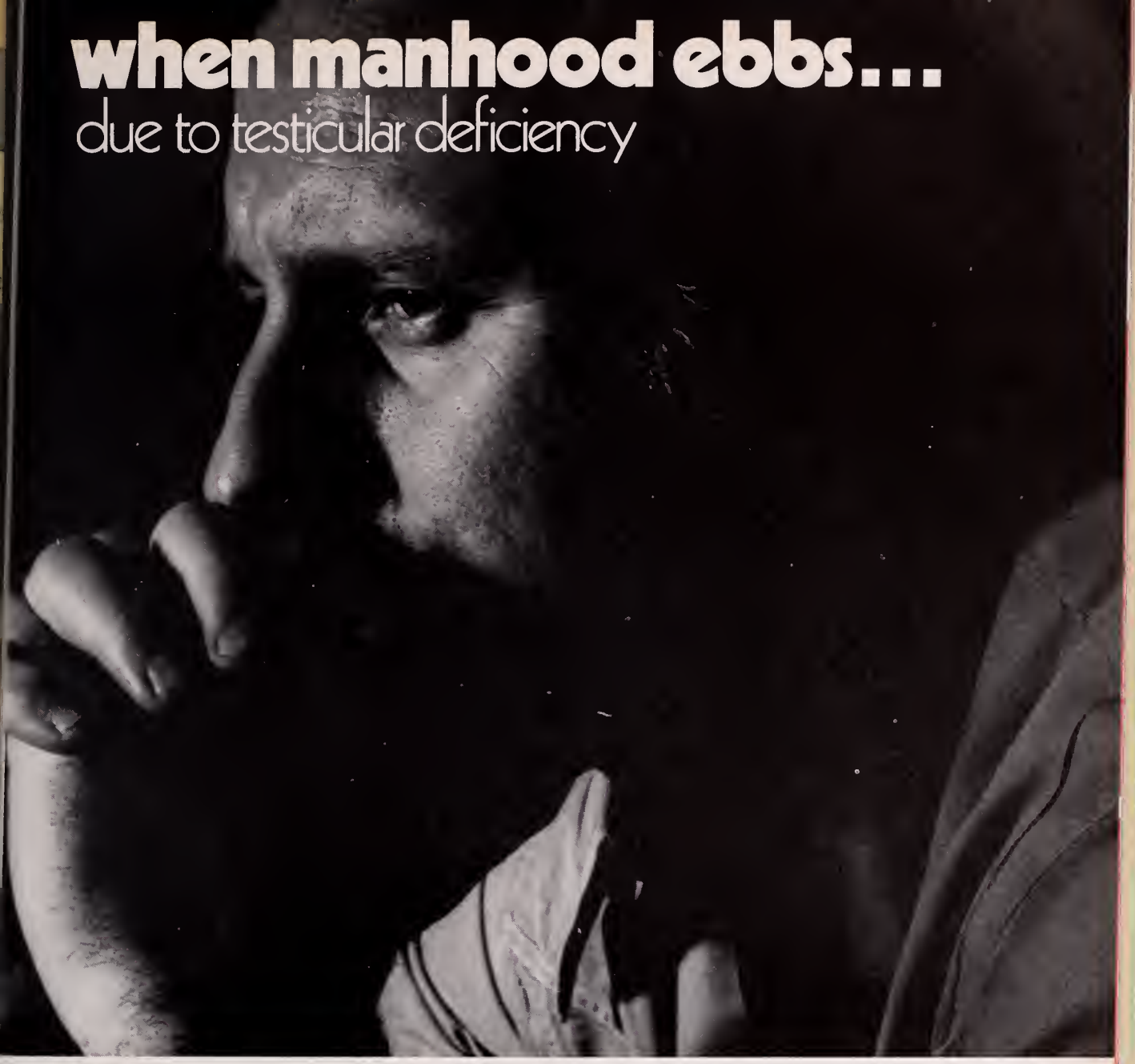

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Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
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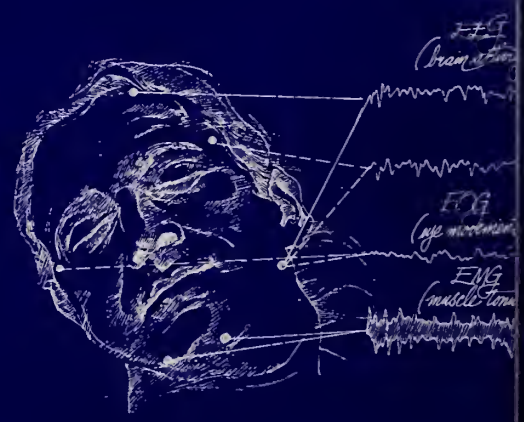

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Editorials

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Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Freedom of Choice

GEORGE H. MAHON has been chairman of the Appropriations Committee of the House of Representatives since 1964, and a member of Congress since 1934. When he spoke to eighteen of us recently,* he pointed out that it was the right of the American public to spend itself into bankruptcy if it so wished. He actually used a more direct expression, but of course he was not recommending that we do so. He was illustrating a point that concerns us all: just how far into free choice does "freedom" go?

As physicians we are accustomed to decisions. We like to believe that our decisions are based on sufficient information, that these decisions follow careful logical processes, and that the ultimate welfare of the patient is thereby better served. We are now moving into a period of American Medicine where there are two significant changes in this otherwise reasonable decision process. One change is that the patient, the ultimate consumer, is now going to be part of the picture. We cannot really argue with the principle for our patients really do deserve to be heard. But to what extent the patient's judgment of what is best for him is truly informed might well be questioned, and will be in countless hospital and community committees in the years to come.

A second change in our decision-making system comes from outside. Other groups are demanding that they be made available upon "patient's freedom of choice." Recently this issue came up in regard to the payment of psychologists for their independent practice of psychotherapy. The psychologists believe that the public is entitled to freedom of choice in treatment of emotional disorders, and further that both government and private insurers should pay the psychologists directly and not as part of a medical prescription. There has not been much progress for the psychologists at the national level, and late in February the Wisconsin Assembly's Insurance and Banking Committee voted 5 to 3 to postpone indefinitely a measure to provide for insurance coverage of psychologists' services under health and accident policies and government Medicaid. Well, so be it. As an individual, I cannot get too excited about this one, for I have been

* Brookings Institution, Seminar for Psychiatrists on Federal Policy-Making Processes.

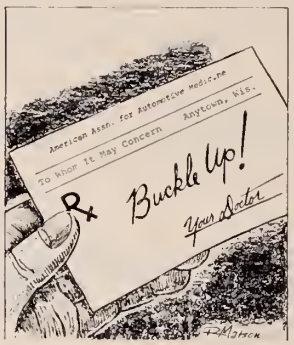
trained in both psychiatry and psychology, and am licensed and professored in both. At least I believe I can adequately grasp the complexities of both training programs. To what extent the public is capable of deciding between medical and non-medical treatment, I have less an adequate grasp. But here is a good example of what Representative Mahon was talking about, the right of peoples to make choices for themselves, even if it means economic bankruptcy as he was illustrating, or in the illustration here of the choice between psychologist and psychiatrist.

Another human right is just now in the spotlight. The immensely complex problems surrounding abortion can illustrate the freedom-of-choice issue now under discussion. In this particular editorial there will be no polemics on the burning issues about abortion: whether the Supreme Court's point of view in its recent decision is correct, that abortion prior to the last three months of pregnancy is a matter of personal decision; whether the unborn child is entitled to advocacy against its avowed attackers; or even whether those who hold either view can force their view on all the population. We will be concerned here with the growing pressure toward individual choice as opposed to either medical or moral judgment over the several issues. That a person should be actually free to seek medical help, or free to refuse medical help, or free to determine his own future, or free to make choices that may not seem real, wise, or healthy is the emerging issue! Freedom to make a mistake may not match our scientific sensibility. Freedom to behave other than in what we have learned was a moral manner may offend our more personal sensibilities. But does it not seem we are moving thusly?

The pressures we feel are broadly based in the population and do not represent the machinations of any person, or any group of legislators or any group of similarly trained persons. I cannot venture into social prophecy, although I'd dearly love to, but my job on these pages is to identify what is indeed happening in our medical world so we can all decide where we fit in that scheme. If the two dissimilar examples given here do happen to identify a trend, then some of us will be mightily unhappy, some will be puzzled and some might feel better within themselves. It's an interesting movement away from medical primacy.—RH

Rx: Buckle Up!

Dr. James L. Weygandt, newly elected president of the American Assn. for Automotive Medicine, has advised Washington that this group "strongly supports the National Highway Traffic Safety Administration in the development and promulgation of a Highway Safety Program Standard which will require that states enact legislation mandating the use of occupant restraint systems."



The automotive medicine professionals further intend to "support efforts of the states to enact such legislation."

In other words, the medical people like safety belts and what they can do to minimize the danger of death and severe injury in highway crashes, and believe their use should be required by law. They should know.

Such a measure will be introduced in the 1973 Wisconsin legislative session. It has come down to this because it now appears that all other reasonable possibilities have been exhausted. "Buckle up" campaigns have not impressed most motorists, and the built-in "buzzer" reminders in late-model cars have been described as a failure.

The fact that doctors support mandatory safety belt use should weigh heavily with legislators, and with all of us.

If we want to stay well, we should follow our doctors' advice.—Reprinted with permission from Wisconsin Traffic Safety Reporter, December 1972

Plaudits to Edgewood College

Elsewhere in this issue is an announcement of Edgewood College's plans to offer a registered nurse the opportunity to obtain a bachelor's degree. To the best of our knowledge, this marks the first time that a degree-granting institution has recognized in a formal manner, the work done by a nurse in her training. To award college credit hours for this customarily three-year hospital diploma preparation is a milestone and long overdue. Edgewood College is to be commended for its foresight.—RH □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Abortion Stand Praised

TO: ROBERT F. PURTELL, MD, *President:* Your editorial (Something of Value) in the February issue of the *Wisconsin Medical Journal* was most gratifying to those of us who are opposed to the wanton destruction of innocent human life.

I am taking the liberty to enclose a copy of Assembly Bill 57, which was introduced into our State Legislature on Jan. 5, 1973 by Assemblyman Lloyd Barbee. It will answer the question in your editorial, "What next?" The copy was given to me by the assistant administrator of one of our local hospitals.

Most of my colleagues upon seeing the bill, stated, "That will never pass. It's unconstitutional!" I, myself, do not feel so confident. How constitutional is the destruction of human life that the Supreme Court has just legalized?

Thank you for the timely editorial and may God bless you!

ANN CINELIS, MD, Sheboygan

Nicaraguan Help Explained

TO: EARL R. THAYER, *Secretary:* We would, all of us in the Nicaragua–Wisconsin Partner Organization, like to express our immense pleasure at the response of the Wisconsin Physicians to the Medical Society's appeal for medical manpower to be of possible assistance in Nicaragua. The Nicaragua and the Wisconsin Medical Societies formed their own personal partnership in 1968.

The situation in Nicaragua, as you know, has many facets. First of all, there was the immediate emergency in which there were teams from the Army Medical Corps flown in from Panama along with groups from Guatemala, France and several other vicinities. They were able to take care of the immediate needs satisfactorily and, as you know, the two emergency Medical Field Hospitals brought in by the U.S. Government have now been turned over to the Nicaraguans. With eighty per cent (80%) of the city of Managua destroyed, and most of the people evacuated to nearby and even remote towns, the care of these people has become the immediate responsibility of such cities as Granada, which was swollen from 30,000 to 80,000 inhabitants. Cities like Leon, where the Medical School is, and Masaya likewise received large increases in population, more than doubling the previous population. Doctor Jose Canton, head of the Nicaragua–Wisconsin Partner organization in Nicaragua, for example, has one hundred fifty (150) people living in his backyard in Granada. Almost all of the physicians in Managua found themselves without an office or a hospital in which to practice and so often dispersed themselves throughout the country to these border towns since they had no other recourse.

Housing has been at a premium in both Managua and these other cities as you can see.

We share with you the desirability of members of our volunteer group from the State Medical Society participating in the relief work, but as you can see, there are problems to be licked. Since the Medical Society of Wisconsin and the Medical Society of Nicaragua are partners in every sense of the term, I think that it would be appropriate for Doctor Robert Purtell to write directly to the head of the Nicaraguan Medical Society offering our assistance.

We would want to be certain that a volunteer or volunteers from Wisconsin could make a real contribution to the cause. In our partner relationships with Nicaragua we have always made certain that any response on our part was the result of a request on their part. If true needs develop in the future, which well might, this would be a good mechanism for making our efforts appropriate.

When the Governor issued his earliest plea, he considered mobilizing the 44th General Hospital. When it was learned that the two mobile U.S. Hospitals would be turned over to the Nicaraguans, there was talk for a time that we might have to staff one or both of these Hospitals. As matters have stood, however, these Hospitals currently are adequately staffed by displaced doctors from Nicaragua.

Dr. Victor Falk made arrangements to go to Managua prior to the Earthquake in order to help them set up an intensive care unit at their largest hospital. With this hospital, as well as the other two hospitals now in shambles, this is no longer possible though he will be called upon to make some contributions during his stay in Nicaragua, which will be part of the greater trip which he and his wife are taking. Doctor Falk, as you know, spent a month in Bluefields, on the East Coast, several years ago and made a very fine contribution. Dr. Fritz Koeneke also spent a month in Nicaragua, and just recently Doctor Lobeck and Doctor Segar were on the East Coast helping with the Wisconsin Medical Students, ten of whom spend periods of three months on the East Coast. Other medical personnel have also worked there from time to time.

There is a problem of transportation as you can imagine, since the Nicaragua and Wisconsin Partners have no source of income. Support for transpor-

tation to and from Nicaragua has been at times covered by the National Partners who have a small amount of money for this purpose, though this has been markedly curtailed and most of the interchange has been at the participant's expense. We have tried for years to get permission to use National Guard planes for this type of transportation as well as contributions by the Nicaraguan National Airlines, but this has not materialized. In the case of the National Guard—this is against "policy." I do think, however, that it would be extremely appropriate to make overtures to the Medical Society of Nicaragua whose President was Dr. Noel Sandino whom we have contacted in care of Dr. Jose Canton in Granada, Nicaragua.

We will look forward to hearing of developments and Dr. Ned Wallace, who is frequently in radio-contact with Nicaragua and who was there only last week (late February), can be of considerable help in this regard. Incidentally, in all of our public appearances we have made it a point to emphasize the fine response the Physicians in Wisconsin have made to this initial appeal.

HENRY A. PETERS, MD, Madison
President
Wisconsin/Nicaragua Partners

Dilemmas in Drug Nomenclature

TO: V. S. FALK, MD, *Medical Editor:* I have compiled a listing of drugs whose names look alike or sound alike. When a pharmacist takes a prescription over the telephone or attempts to decipher a physician's handwriting, a drug product not intended by the prescriber might be dispensed. Such an error might be the result of a sound-alike or look-alike drug.

I am enclosing (below) a partial list of such drugs with striking similarities. Physicians are urged to exercise great care when writing or telephoning prescriptions.

BENJAMIN TEPLITSKY, RPh, Brooklyn, NY

Dilemmas in Drug Nomenclature

Aerolone	Aralen	Arlidin
Cardilate	Cardalin	Calcidin
Digoxin	Desoxyn	Digitoxin
Isordil	Isuprel	Inderal
Levophed	Levoprome	Levorenine
Pavabid	Paveril	Pavased
Peritrate	Pentryate	Lotusate
Persantine	Trasentine	Pertofrane
Pronestyl	Promensin	Ponstel
Unitensin	Salutensin	Diutensin
Vasal	Vasodilan	Vontrol
Vastran	Vesprin	Vasodil

Understanding the Limbic System

In recent years our greater knowledge of the psychoneuroses has shown that certain disease processes may have their origin in psychopathology rather than tissue pathology, or a combination of both. This etiologic relationship is based on psychiatric observations as well as investigations of the neural pathways through which psychosomatic phenomena may operate. The latter investigations helped to localize the mechanics in the central nervous system that were concerned with the experience of emotions and its elaboration into behavior. Extensive studies done by many neurophysiologists have suggested ways in which the limbic system may be involved with psychosomatic disease.

For a better understanding of these phenomena, we are pleased to send you the monograph, AKERT and HUMMEL: *The Limbic System—Anatomy and Physiology* for your State Society library. We hope that it will be of value to the members of your Society.

M. WILLIAM AMSTER, MD
Assistant Director
Professional Relations
Roche Laboratories
Nutley, New Jersey 07110

EDITOR'S NOTE: For details in ordering the book, refer to the BOOKSHELF section of this issue. □

AMERICAN COLLEGE OF CHEST PHYSICIANS has established a new program that will bring top experts on respiratory diseases to medical schools and community hospitals for several days of consultation and teaching. The new "Professors in Residence" program—made possible by a grant from Breon Laboratories—will be administered by the ACCP Committee on Postgraduate Medical Education. According to Dr. Howard S. Van Ordstrand, chairman of the committee, recognized authorities on pulmonary disorders will be invited to spend two or three days at a medical school or a hospital, as teacher-consultants to medical students, house staffs, and community physicians. If requested, Dr. Van Ordstrand noted, the authorities will evaluate the hospitals' facilities for diagnosis and treatment of respiratory illness.

HOW THE
State Medical Society of Wisconsin
SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use, and to serve. To benefit fully from membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the fourth in a series of articles explaining State Medical Society organization and activities.

Service to Individual Members is a Major Society Effort

MANY OF THE State Medical Society's services to members are provided on an individualized basis in response to personal requests and needs. The Society's commissions, committees, and staff deal regularly with problems and questions pertaining to special situations in areas such as physician placement, hospital relations, and military service.

Physician Placement

Whenever a doctor is looking for a place to practice in Wisconsin—whether he is just out of school or seeking a change—his best bet is the Society's physician location service. This service keeps complete, up-to-date files on places which have requested physicians as well as physicians seeking locations.

For the asking, a physician can get a full list of opportunities for full-time individual practice, locum tenens positions, partnerships, and group or clinic practice. The Society cooperates with the American Medical Association's placement service to give physicians first-hand information on a national basis.

Questions About Medical Products and Devices

Whenever a physician has questions about drugs, diagnostic and therapeutic devices, and other products used in the practice of medicine, he should feel free to write or call the State Medical Society. Hundreds of such requests are answered each year. Most of these products and devices are evaluated or tested by the American Medical Association or the FDA. The doctor may contact the AMA directly or ask the State Society for help.

The Doctor and the Hospital

Sometimes it isn't easy for the physician to find a local solution to problems of hospital medical staff bylaws or medicolegal aspects of care in a hospital or medical staff–administration relationships. That's where the State Medical Society can help.

Through its Commission on Hospital Relations and Medical Education (CHRME) and the staff, a good deal of valuable information and experience can be brought to bear on the member's problem. Sometimes situations can be resolved before they become problems; in more serious cases specific complaints from physicians or hospitals can be adjudicated. Help is available, too, as to suitable financial and contractual relationships between physicians and hospitals.

Personal Insurance for Members

Of direct and personal benefit to a member of the State Medical Society is his eligibility to enroll in the Society's group insurance plans.

WPS, the State Medical Society's Blue Shield plan, makes available hospital–surgical–medical and major medical protection for members and their families on a group basis. This group was created especially for State Society members.

Income protection against disabilities arising from accidents or sickness is offered through the Provident Life and Accident Insurance Company. The insurance is available to Society members less than 70 years old who are in the active practice of medicine in the state of Wisconsin. Benefits for insured members are available through age 74. Eligible members may obtain the protection without submitting the usual health questionnaire, providing their application is made soon after becoming a State Society member. New members of the Society who are under age 34 may apply within one year and the members over 34 within six months without consideration of past medical history or physical condition.

Term life insurance policies for up to $75,000 are available to active members of the Society. This policy can be converted to a permanent form of insurance at any time after the term insurance is issued. The life insurance is underwritten by the Bankers Life Company of Des Moines, Iowa.

Business overhead insurance provides members with protection for office and business expenses in event of a disability. Benefits up to $1,000 per month are available to all members of the State Society who are under 70 years of age. The plan is insured by Continental Casualty Company.

Also through the Society the Seefurth–McGiveran Corporation offers a number of ways in which physicians can set up their own retirement investment program.

Records of All Physicians

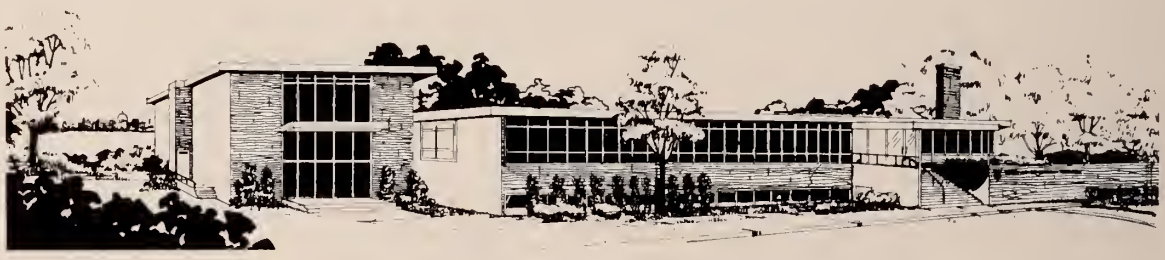
The membership department of the Society keeps detailed computer records on every physician in the state. This data is invaluable in providing endorsements for reciprocity; adjudicating dues problems; providing information on the location of physicians, board-certified specialists, and qualifications of all physicians; identifying those who improperly pose as MDs; locating colleagues; and determining the number and distribution of physicians. The Society's membership department also handles all mechanical details of obtaining physician participation in the prepaid insurance plans, physicians' disability plan, and the open panel program.

"Personal Service" to Physicians

A tremendous amount of the Society's effort can be classified in no other way than as "personal service" to individual physicians. Day-to-day correspondence between members, the public, and the Society is responsible for much staff time and effort. Each of the inquiries presents a particular problem; and while some may be relatively routine, others require detailed study and research, conferences for a decision on means of expressing the Society's policy, and sometimes reference to appropriate committees or councils of the Society for final determination.

Medicolegal problems constitute a large proportion of such inquiries. Typical of these are requests for information on the legal aspects of medical testimony, sale and use of narcotics, access to hospital records, Workmen's Compensation Act and estimation of permanent disability, release of information about patients to the press, licensing, establishing and operating a practice, and an almost unlimited number of similar questions.

The Society also helps its member physicians by providing facts on business methods, insurance and financial problems, taxation, medical care costs, state and federal legislation, physician and hospital relations, medical education, hospitals and physician supply and distribution. □



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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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MANPOWER by Specialty in Wisconsin

DONALD R. KORST, MD
Madison, Wisconsin

A RECENT REVIEW of manpower needs by specialty in the United States by Mason[1] of the American Medical Association suggests that problems in some areas may be due to distribution rather than shortages of physicians. In this article, he presents physician-population ratios broken down by state for twenty medical specialties (including family practice), as well as optimum ratios established by experience of six large prepaid group plans. The data are from AMA records for 1970 of active practicing physicians and house officers (interns and residents) based on 1970 population released by the U.S. Bureau of the Census. Other data of physicians in practice are available from the AMA[2] and the Wisconsin Bureau of Health Statistics.[3]

Methods

The data expressed in Tables 1 and 2 have been derived as follows: Table 1, column 1, is the total active physicians including non-federal and VA-employed who identify themselves for AMA and state records as being primarily engaged in a specialty category of medical practice (including general practice). Excluded are those physicians predominantly in research or administration. Physicians based in a hospital or employed for teaching but also primarily in patient-care are included. Table 1, columns 2 and 3, are based on the data from all states[1] compared to Wisconsin physician distribution using figures from the United States Bureau of Census, 1970 which does not include military personnel. Averages are based on 50 states and the District of Columbia. Table 1, columns 4 and 5, is the same data expressed as percentage of the spe-

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cialty group to the total physicians in the United States and Wisconsin. Table 1, column 6, is data of physician-population ratios based on the author's extrapolated means from Table 2 of Mason's report.[1] The six prepaid group plans referred to are HIP (Hospital Plan of Greater New York), Kaiser-Permanente Plans, and Group Health Associates, Washington, D. C. Table 1, column 7, is the same data as column 2 except is expressed as median population rather than average population.

The data in Table 2 are for house staff (interns and residents or fellows) expressed as a ratio to average physician population by specialty in column 1 and column 2. The data expressed in columns 3 and 4 are a comparison of total United States and Wisconsin figures based on numbers of specialists in the same field of training as the house staff. The data in Tables 1 and 2 are based on total physicians by state and specialties without regard for distribution within the state.

Table 3 expresses the total number of physicians, the population-per-physician ratio, and the percentage of specialists to total physicians for comparison to Table 1, columns 4 and 5. Data in Table 3 are arranged by districts from the Bureau of Health Statistics data.[3] The districts are grouped by counties (Fig 1,[9] as follows: District 1, Southern is 11 counties, population 759,466 and 894 physicians; District 2, Southeastern is 7 counties, population 1,755,887 and 1,855 physicians; District 3, Lake Winnebago is 8 counties, population 439,776 and 376 physicians; District 4, Lake Michigan is 9 counties, population 472,985 and 330 physicians; District 5, Western is 7 counties, population 204,-299 and 161 physicians; District 6, West Central is 9 counties, population 303,397 and 215 physicians; District 7, North Central is 11 counties, population 327,142 and 291 physicians; and District 8, North Western is 10 counties, population 154,879 and 74 physicians. Madison is in District 1; Milwaukee, Racine and Kenosha are in District 2; Green Bay and Sheboygan are in District 4; La Crosse is in District 5; Eau Claire is in District 6; and Marshfield is in District 7.

The total number of physicians listed as direct-care are 79% of Wisconsin physicians (4,195 of

TABLE 1—*Physicians by specialty in Wisconsin compared to total United States*

	Total Number of Active Physicians in Wisc. (Exclude Research, Federal Administration)	Population Per Physician in the United States	Population Per Physician in Wisconsin	Percent of Specialty Group to All U. S. Physicians	Percent of Specialty Group to All Wisconsin Physicians	Population Per Physician Mean of Six Large Prepayment Groups	Median State Ratio in U.S.A.
All Physicians (Non-Federal and Excluding Research or Administration)	5,176	715	815	%	%	1,061	
Specialty Groups							
Anesthesia	197	20,264	22,426	3.5%	3.8%	47,000	29,444
Dermatology	71	57,322	62,224	1.2	1.4	53,100	72,000
Family Practice	1,239	3,601	3,565	19.8	23.9	5,217	3,459
General Surgery	458	7,554	9,646	9.4	8.8	12,487	8,223
Colon-Rectal Surgery	12	322,019	368,161	0.2	0.2		213,636
Thoracic Surgery	23	126,437	192,034	0.6	0.5		182,500
Internal Medicine	729	4,474	6,060	16.2	14.1	4,265	5,894
Neurology	57	85,768	77,580	0.8	1.1	109,500	125,000
Neurosurgery	41	87,017	107,754	0.8	0.8	110,900	104,166
Ob-Gyn	271	11,918	16,302	6.0	5.2	10,520	14,299
Ophthalmology	191	22,255	23,131	3.2	3.7	41,300	26,129
Orthopedics	151	23,519	29,258	2.9	2.9	28,150	26,538
Otolaryngology	87	41,722	50,781	1.7	1.7	44,870	48,552
Pathology	175	23,913	25,245	2.9	3.4	89,360	30,286
Pediatrics	249	12,795	17,743	5.6	4.8	6,967	17,000
Plastic Surgery	34	135,457	129,939	0.5	0.7	485,000	188,000
Psychiatry	308	10,384	14,344	6.8	6.0	81,170	16,730
Rehabilitation	23	159,736	192,084	0.5	0.5	105,600	278,571
Radiology	261	16,722	16,927	4.2	5.0	33,500	19,286
Urology	103	37,943	42,892	1.9	2.0	61,400	43,800

5,340) according to the state figures. The remaining 21% (1,145) are listed as house staff 13%, medical research and teaching 5%, administration 2%, and other 1%. It must be remembered that most physicians listed as research and teaching also participate in patient-care activities as much as 50% of their time. It should be noted that the AMA[2] and the State Bureau[3] figures for each specialty differ slightly.

Discussion

The present and future needs of the state for physicians may be estimated by projection of present national trends in postgraduate medical education. The majority of students (90–95%) plan to follow some additional training in an area of special interest, all of which require two to three years beyond the internship including family practice programs. Indeed, the internship is now the first year of graduate training in most specialties. The growth of medical schools has perhaps now met the total

TABLE 2—*Physicians by specialty in Wisconsin compared to total United States*

	Percent of House Staff to All U.S. Physicians	Percent of House Staff to Wisconsin Physicians	Percent of House Staff in Specialty to Total U.S. Specialists in Same Field	Percent of House Staff in Specialty to Wisconsin Specialist in Same Field
All Physicians (Non-Federal and Excluding Research or Administration)	3.3%	2.4%	%	%
Specialty Groups				
Anesthesia	0.5%	0.3%	13.3%	8.1%
Dermatology	0.2	0.2	13.6	15.5
Family Practice	0.4	0.3	2.1	1.4
General Surgery	2.3	1.7	25.2	19.0
Colon-Rectal Surgery	0.2	0.2	3.2	0
Thoracic Surgery	0.1	0.1	11.0	4.3
Internal Medicine	3.3	2.4	20.6	17.3
Neurology	0.2	0.3	28.1	29.8
Neurosurgery	0.2	0.1	21.2	7.3
Ob-Gyn	0.8	0.5	13.7	10.3
Ophthalmology	0.4	0.5	13.4	14.1
Orthopedics	0.5	0.5	18.8	17.8
Otolaryngology	0.3	0.3	15.2	20.7
Pathology	0.7	0.4	24.9	12.6
Pediactrics	1.2	0.8	2.1	1.6
Plastic Surgery	0.1	0.1	16.3	17.7
Psychiatry	1.2	0.9	17.5	14.9
Rehabilitation	0.1	0	17.7	0
Radiology	0.9	0.9	21.0	18.3
Urology	0.3	0.3	14.2	13.6

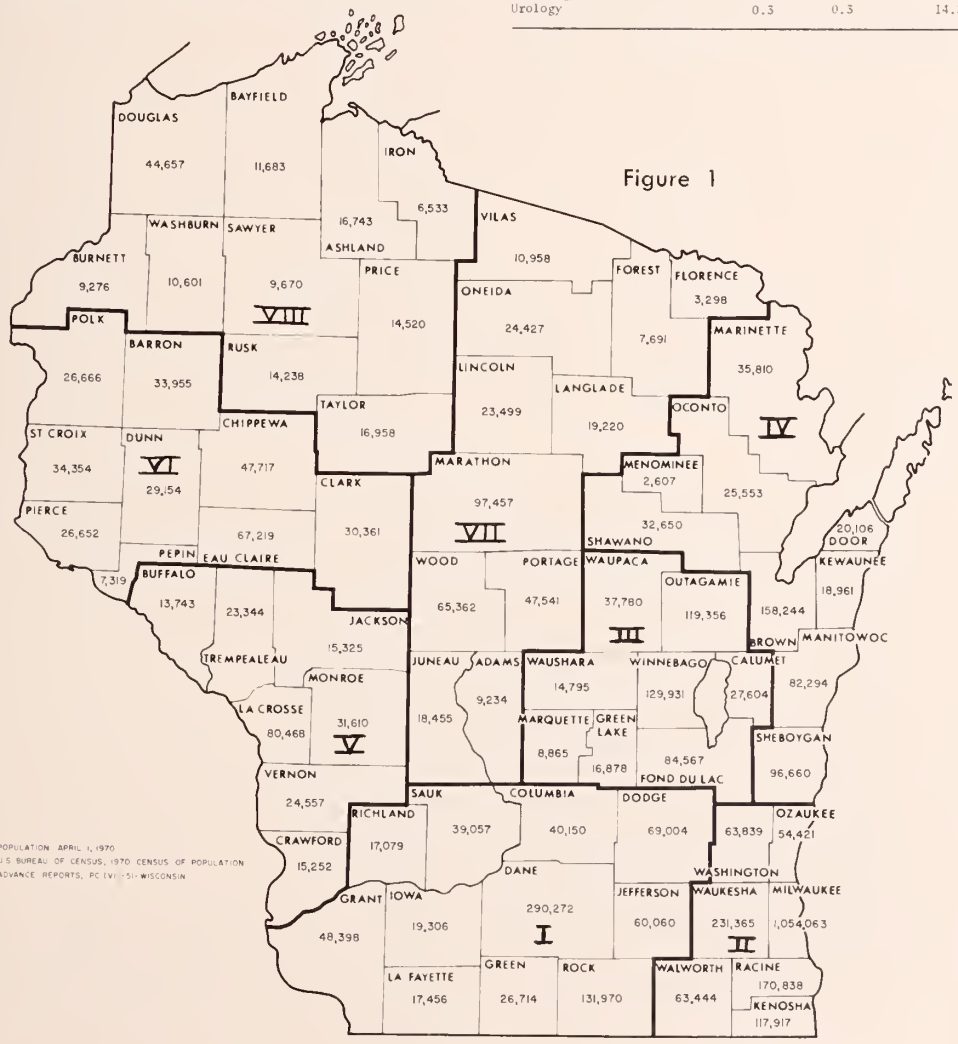

Figure 1

manpower needs or at least the present ten-year projection.[4] Therefore, it would appear that some consideration be made to determine the needs in postgraduate education and distribution of specialty.[5] A number of factors have influenced the present trends of physician distribution such as the growing sophistication and educational levels of the general population, the increasing complexity of care with its demands on professionals and other resources, the expanding role of the hospital health-care center, and the improved methods of communication and transportation.[10]

The review of statistics in this report is based on the 1970 census and augments the report of Coye and Stokes[6] in 1967. The population trends for the 60s projected in the Coye report appear to be unaltered by current data.[7] Of considerable interest is data now available concerning the experience of six large group health-care programs.[1] The overall growth of house officers (graduate training for interns and residents) has been surveyed in 60 teaching hospitals by the Council of Teaching Hospitals of the American Association of Teaching Hospitals.[8]

The author has chosen to express all of the data in Tables 1, 2 and 3 so that the readers can make their own interpretation. In addition some conclusions by the author become apparent as follows:

[1] Overall physicians in Wisconsin should be increased by between 700 and 800 to be at a national average. This figure might be less if the experience of six large group practices is correct. Wisconsin presently has one physician per 815 population compared with the national ratio of 715. Experience in six large group practices has been based on a ratio of 1:1061.

[2] The present distribution of physicians in the state by type of practice is 79% in direct patient care, 10% residents, 3% interns, 5% teaching, 2% administration, and 1% other functions. It must also be considered that intern, resident, hospital, teaching, and research physicians are involved in patient care, 50% or more of their time with only a few exceptions. The practice patterns are self 32%, group 21%, partners 15%, hospitals 19%, medical school 8%, and government 3%. The current trend for recent graduates to choose group practice would probably influence the 21% group practice figure. Age distribution is 35% under age 40, 28% in the 40–50 age group, 25% in the 50–65 age group, and 12% over age 65. The usual age of a graduating medical student is 26 years and he has usually completed postgraduate training and military commitments by the age of 32.[3]

[3] The medical school source of Wisconsin physicians is the University of Wisconsin and the Medical College of Wisconsin 44%, neighboring states 20%, other states 21%, foreign graduates 13% (Asia 50%, Europe 32%, Central American 8.5%, and Canada 7.5%), and Doctors of Asteopathy 2%.[3] Of all of the specialists indicated in the United States of America, 62% are board certified and the remainder are board eligible or self-designated. In Wisconsin the total number of specialists board certified is 43%.[1] In Wisconsin 31% of physicians in practice identify as general practice, 28% as surgical specialty, 19% as a medical specialty, and 23% as another specialty.

[4] Wisconsin needs more physicians trained in anesthesia, dermatology, internal medicine, neurology, obstetrics-gynecology, orthopedics, otolaryngology, pediatrics, psychiatry, rehabilitation, radiology, and urology based on comparison with the national average of other states. If one uses the criteria of needs of population to specialty physicians established in the experience of six large health-care groups, then the needs in Wisconsin would be primarily in dermatology, internal medicine, neurology, obstetrics-gynecology, orthopedics, otolaryngology, pediatrics, and rehabilitation. The greatest needs in increase of total numbers of new physicians to provide specialty group practice in Wisconsin appear to be in pediatrics, obstetrics-gynecology, and internal medicine. A lesser number of physicians are needed to increase some more specialized areas such as anesthesia, dermatology, orthopedics, otolaryngology, neurology, rehabilitation, urology, radiology, and perhaps psychiatry.

Distribution is a factor and the needs for a great increase in numbers might be questioned in such areas as anesthesia, ophthalmology, pathology, plastic surgery, radiology, psychiatry, and urology. It is apparent that the northern areas of the state demonstrate the factors of maldistribution. Certain specialties such as dermatology and neurology are poorly distributed.

Family practice and general surgery in Wisconsin are fairly close to the national averages and considerably better in physician-to-population ratio than the experience in the six large practice groups. Neurosurgery, ophthalmology, and plastic surgery appear to be in pretty good balance by national average.

[5] The training programs for interns and residents in Wisconsin are considerably behind the national average.[8] During the period 1965–1969 the total number of interns on the national level has increased 20.5%; the total number of residents

TABLE 3—*Manpower distribution of physicians by specialty in Wisconsin*[3]

Specialty (Total)		1 Southern	2 South-Eastern	3 Lake Winnebago	4 Lake Michigan	5 Western	6 West Central	7 North Central	8 North Western
Anesthesia (186)	Number	43	98	16	10	3	6	9	1
	Ratio	17,662	17,917	27,486	47,299	68,100	50,566	36,349	154,879
	Percent	4.8%	5.3%	4.3%	3.0%	1.9%	2.8%	3.1%	1.4%
Dermatology (60)	Number	12	29	4	5	2	4	4	0
	Ratio	63,289	60,548	109,944	94,597	102,150	75,849	81,786	0
	Percent	1.3	1.6	1.1	1.5	1.2	1.9	1.4	0
Family Practice (1,287)	Number	250	449	140	138	54	121	88	47
	Ratio	3,039	3,911	3,141	3,427	3,783	2,507	3,718	3,295
	Percent	28.0	24.2	37.2	41.8	33.5	56.5	30.2	53.5
General Surgery (374)	Number	64	172	34	35	17	20	25	7
	Ratio	11,867	10,209	12,935	13,519	12,018	15,170	13,086	22,126
	Percent	7.2	9.3	9.0	10.6	10.6	9.3	8.6	9.5
Colon-Rectal Surgery (17)	Number	1	11	1	0	2	1	1	0
	Ratio	759,466	159,626	439,776	0	102,150	303,397	327,142	0
	Percent	0.1	0.6	0.3	0	1.2	0.5	0.3	0
Thoracic Surgery (24)	Number	8	12	1	0	1	0	4	0
	Ratio	126,578	146,324	439,776	0	204,299	0	81,786	0
	Percent	0.7	0.6	0.3	0	0.6	0.6	1.4	0
Internal Medicine (639)	Number	144	321	39	38	24	18	50	5
	Ratio	5,274	5,470	11,276	12,447	8,512	16,855	6,543	30,976
	Percent	16.1	17.3	10.4	11.5	14.9	8.4	17.2	6.8
Neurology (36)	Number	14	15	1	0	2	0	4	0
	Ratio	54,248	117,059	439,776	0	102,150	0	81,786	0
	Percent	1.6	0.8	0.3	0	1.2	0	1.4	0
Neurosurgery (38)	Number	9	17	3	4	2	0	3	0
	Ratio	84,385	103,287	146,592	118,246	102,150	0	109,047	0
	Percent	1.0%	0.9%	0.8%	1.2%	1.2%	0%	1.0%	0%
Ob-Gyn (241)	Number	46	128	19	17	10	5	14	2
	Ratio	16,510	13,718	23,146	27,823	20,430	60,679	23,364	77,440
	Percent	5.1	6.9	5.1	5.2	6.2	2.3	4.8	2.7
Ophthalmology (159)	Number	36	67	15	13	8	4	10	6
	Ratio	21,096	26,207	29,318	36,383	25,537	75,849	32,714	25,813
	Percent	4.0	3.6	4.0	3.9	5.0	1.9	3.4	8.1
Orthopedics (125)	Number	31	56	11	11	3	3	10	0
	Ratio	24,494	31,355	39,980	42,999	68,100	101,132	32,714	0
	Percent	3.5	3.0	2.9	3.3	1.9	1.4	3.4	0
Otolaryngology (70)	Number	17	32	7	6	3	2	3	0
	Ratio	44,674	54,871	62,825	78,831	68,100	151,699	109,047	0
	Percent	1.9	1.7	1.9	1.8	1.9	0.9	1.0	0
Pathology (126)	Number	30	65	7	7	3	3	11	0
	Ratio	25,316	27,014	62,825	67,569	68,100	101,132	29,740	0
	Percent	3.4	3.5	1.9	2.1	1.9	1.4	3.8	0
Pediatrics (185)	Number	37	96	18	10	4	3	15	2
	Ratio	20,526	18,290	24,432	47,299	51,075	101,132	21,809	77,440
	Percent	4.1	5.2	4.9	3.0	2.5	1.4	5.2	2.7
Plastic Surgery (26)	Number	5	16	2	2	0	0	1	0
	Ratio	151,893	109,743	219,888	236,493	0	0	327,142	0
	Percent	0.6	0.9	0.5	0.6	0	0	0.3	0
Psychiatry (251)	Number	69	114	31	12	6	9	10	0
	Ratio	11,007	15,403	14,186	39,415	34,050	33,711	32,714	0
	Percent	7.7%	6.1%	8.2%	3.6%	3.7%	4.2%	3.4%	0
Rehabilitation (33)	Number	4	21	2	1	2	0	3	0
	Ratio	189,867	83,614	219,888	472,985	102,150	0	109,047	0
	Percent	0.4	1.1	0.5	0.3	1.2	0	1.0	0
Radiology (195)	Number	46	82	16	14	7	10	19	0
	Ratio	16,510	21,413	27,486	33,745	29,186	30,340	17,218	154,879
	Percent	5.1	4.4	4.3	4.2	4.3	4.7	6.5	1.4
Urology (88)	Number	20	36	10	8	4	3	7	0
	Ratio	37,973	48,775	43,978	59,123	51,075	101,132	46,735	0
	Percent	2.2	1.9	2.7	2.4	2.5	1.4	2.4	0

Ratio = Population per physician

Percent = Number of specialists to total physicians for comparison with Table 1, columns 4 and 5

Variations in total physicians by states and districts vary from AMA Report and State Statistics Report

has increased 30.8%; and the total number of house officer training programs has increased 10.5%. Although I do not have the exact data about house officer training programs in Wisconsin, my estimate of the growth since 1965 is that the number of programs has decreased, and the total increase in interns and residents is perhaps only half of the national average.

Summary

Data related to specialty training and distribution provide parameters for future planning for physician training programs in Wisconsin. Comparisons with experience of physician-population ratios in six large group health-care systems suggest a need to compare numbers and distribution of physicians by specialty training.

Present growth trends appear to be related to group practice. The needs for the greatest increase of physicians in training appears to be in pediatrics, internal medicine, and obstetrics-gynecology. There is also a need for increase in size or number of programs in anesthesia, dermatology, neurology, orthopedics, otolaryngology, psychiatry, rehabilitation, radiology, and urology. The total needs may be altered slightly by changing concepts in group practice and consumer groups, but the needs for increase in certain specialties will probably not change.

An increase in medical school enrollment without attention to planning of postgraduate training and distribution of group practices in the state of Wisconsin will not result in optimal improvement of health-care delivery.

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Glomerulonephritis Associated with Hydrocarbon Solvents: Mediated by Antiglomerular Basement Membrane Antibody

G J BEIRNE, MD and J T BRENNAN, MD, VA Hospital, Madison, Wis: *Arch Environ Health* 25:365–369 (Nov) 1972

In a retrospective study of 13 patients with glomerulonephritis associated with antibodies to glomerular basement membrane, 8 were available for detailed history regarding chemical exposure. Six of these 8 patients had a history of prolonged heavy exposure to various hydrocarbon solvents preceding the onset of their disease. Of the 6 patients with positive exposure histories, 5 also had pulmonary hemorrhage with hemoptysis thereby fulfilling the criteria for Goodpasture's syndrome. The other patient had rapidly progressive glomerulonephritis with extensive epithelial crescents on renal biopsy.

The presence of antiglomerular basement membrane antibody was confirmed in all but one patient by direct immunofluorescence microscopy and circulating antibody was detected in three of four patients tested for its presence.

Often these patients were exposed to a heated vapor or mist of the suspected solvents. Paint remover, degreasing solvents, hair sprays and other painting solvents were extensively used by these patients. Three of the patients with Goodpasture's syndrome had nearly identical jobs cleaning mechanical parts with degreasing and paint removing solvents.

On the basis of this experience we propose that at least in some cases the disease is caused by the toxic effect of inhaled volatile hydrocarbons. Chemical interaction with lung or kidney basement membrane may provoke the immunological response which in turn perpetuates and intensifies the tissue injury.

While retrospective studies can only suggest an etiologic relationship, the theory proposed would perhaps explain why this disease often affects young men in their early twenties when they first enter the job market. Nevertheless, the disease is relatively rare and exposure to solvents is probably widespread so individual host susceptibility is probably an important feature of the problem. □

Saphenous Vein Bypass Grafts for Arteriosclerosis Obliterans in the Femoropopliteal Region

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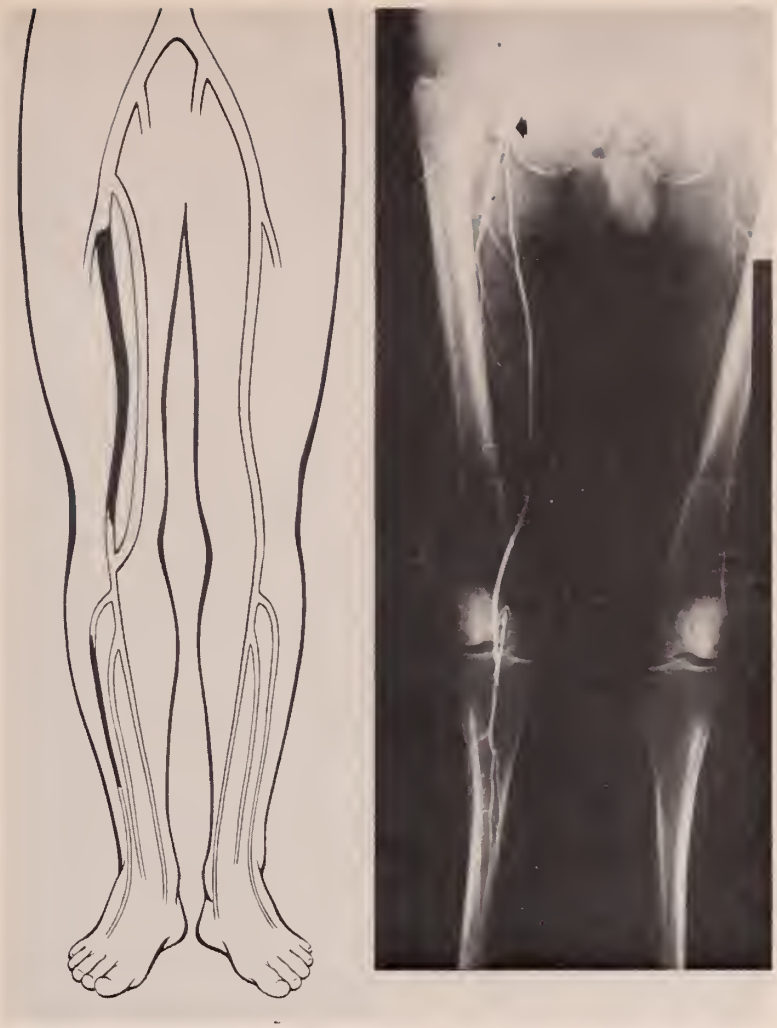

Figure 1—Diagram and femoral arteriogram illustrating bypass of arteriosclerotic occlusion of the femoropopliteal segment with a saphenous vein graft. Arteriogram was done six years after the procedure in a 72-year-old man.

WELL CONTROLLED STUDIES demonstrating the efficacy of vasodilators for arteriosclerosis obliterans are notably lacking, making a surgical approach the treatment of choice. Fortunately, arteriosclerosis obliterans tends to be segmental, involving only the aortoiliac or femoropopliteal segments and sparing the common femoral and distal popliteal segments.

In 1951 Kunlin[1] of France introduced the bypass procedure using reversed saphenous vein as a conduit to bypass arterial circulation around the arteriosclerotic femoropopliteal obstruction in the thigh (Fig 1). Since then several centers have reported successful results using this method.[2-5]

This report comprises 156 consecutive saphenous vein bypass grafts the author performed in 123 patients between June 1962 and December 1971. The average age was 63 years and ranged from 30 to 92. About one-third of the procedures were done for correction of ischemic ulceration or gangrene, one-fourth were done for pain at rest, and the remainder were done to relieve intermittent claudication which curtailed walking at work or leisure.

The history of intermittent claudication, consisting of distress in the calf induced by walking and relieved by a few minutes of rest, is pathognomonic of arteriosclerosis obliterans. If the aortoiliac segment is obstructed, femoral pulses will be absent and intermittent claudication may extend up into the thighs. If the aortoiliac segment is open and the femoropopliteal segment is occluded, intermittent claudication is restricted to the calves. Femoral pulses will be present while popliteal and pedal pulses are absent.

All patients in this series had satisfactory femoral pulses; popliteal and pedal pulses were absent in all, indicating occlusion in the femoropopliteal segment. Flexion of the knee facilitates palpation of the popliteal pulse because the distal popliteal artery can then be pressed against the head of the tibia (Fig 2).

Associated diseases were common. Aortoiliac atherosclerotic disease was present in one-fourth but it was severe enough to necessitate aortofemoral bypass grafting in only 16 patients. Arteriosclerotic heart disease pre-

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viously manifested by myocardial infarction, angina or congestive heart failure existed in one-third. Five percent had a history of stroke but none had significant residual. One-third had blood pressures higher than 140/90 mm Hg. About one-third had diabetes mellitus. Most patients were cigarette smokers. Various degrees of chronic obstructive pulmonary disease were common.

The reversed saphenous vein was implanted by Szilagyi's[6] method, with minor modifications. Transfusions were usually unnecessary. Most often the graft was carried from the common femoral to distal popliteal arteries. This effectively bypasses the superficial femoral artery and proximal popliteal segment, the segment so susceptible to atherosclerotic occlusion. In 17 patients it was necessary to carry the distal anastomoses to tibial or peroneal vessels, occasionally as far as the ankle.

Results

Deaths related to the operation occurred in two cases. The first, a 75-year-old man with gangrene of the toes, died suddenly on the first postoperative day and autopsy revealed extensive coronary disease. The second patient was 57 years old and had claudication only; death on the eighth postoperative day was due to an acute myocardial infarction, confirmed at autopsy.

Eight patients were returned to the operating room on the day of surgery, three for correction of occlusions and five for bleeding. Several others developed hematomas. Bleeding has been rare since deciding to routinely reverse the action of heparin with protamine at the end of the surgical procedure. Skin necrosis, usually after undermining, resulted in delayed skin healing in a few cases, but wound complications never resulted in occlusion of a vein graft. In two patients late stenosis occurred following inadvertent clamping of the saphenous vein with a hemostat during removal. In another stenosis was due to a fibrotic subintimal plaque; all three were remedied with vein patch angioplasties.

On discharge from the hospital 98% had graft patency (Table 1) as manifested by a good popliteal pulse.

Except for two patients who moved away, all have been examined annually. A good popliteal pulse was considered adequate evidence for a functioning graft. Fifty-six postoperative arteriograms from 3 months to 8 years have shown no aneurysmal formation, calcification or degeneration. Fortunately, the saphenous vein is a thick-walled vessel naturally designed for high hydrostatic pressures. Ninety limbs have functioning grafts. Thirty-eight patients had functioning grafts when last seen prior to death from other causes. Grafts have relieved claudication and rest pain. Twenty-eight occluded with regression to preoperative status, but no patient was worse off than he was preoperatively. In two cases the bypass graft only temporarily halted advancing gangrene and above the knee amputations were necessary when the graft occluded. In one case below the knee amputation was necessary for severe ischemic pain.

The average age of 46 patients who died between 1962 and 1971 was two years more than the average age of the entire group. Fifteen lived from two to five years after operation but the remaining 31 died within two years of bypass. About three-fourths of patients in this group had severe ischemia pre-

TABLE 1 —*Early Patency Rates*

	Number	*Early (30 days)*
DeWeese et al	113	76%
Linton et al	295	92%
Lorentsen et al	86	93%
Szilagyi	122	76%
Present Series	156	98%

Figure 2—Arteriogram with knee in flexion demonstrates proximity of the distal popliteal artery to the tibial head. The popliteal artery can be pressed against the tibial head at the arrow.

operatively and sought surgical relief for rest pain, ischemic ulceration, or gangrene. All but six patients had patent grafts at death. Their rehabilitation, relief of pain and salvage of an extremity justified the procedure despite short lives postoperatively.

Graft patency curves have been calculated by the method of Kaplan and Meier[7] for the 156 bypass grafts. The patency observations used were the lengths of time, in months, that the grafts remained functional after operation. The percentage of grafts patent longer than one year is 84%, and longer than five years is 65%. The graft patency curve for the 48 diabetic patients is very similar to the curve for all patients.

Operations were grouped by the run-off, viz. the number of popliteal branches open, and graft patency curves were calculated for each group. No difference was found between those with 3 vessel, 2 vessel, and 1 vessel run-off. Seventeen patients had occlusion of the distal popliteal artery necessitating anastomosis to a tibial or peroneal artery, sometimes as far distally as the ankle. The curve for these is below all others; three failures occurred within three months of operation in this group. However, there are no statistically significant differences among any of the curves (P-value $> .10$ for all comparisons by Wilcoxon text[8]). The patency curve for grafts in patients having ischemic ulceration or gangrene is below those for claudication and for rest pain. However, the patency of grafts in patients having claudication only is not significantly different from those with rest pain and those with tissue necrosis.

Operations were also grouped by diameter of grafts. There is no evidence of a statistically significant factor in duration of patency based on diameter of graft.

Comment

Shepherd,[9] in his textbook, "Physiology of the Circulation in Human Limbs in Health and Disease," writes:

> "Vasodilator drugs have been used extensively in patients with claudication. The large number of publications arguing for or against their use is evidence of the real doubt about their merits. The periodic fluctuations in the severity of symptoms in the natural course of the disease accounts for difficulties in attempting to assess small degrees of improvement. Many of their applications have stemmed from belief in the presence of "spasm" and their capacity to relieve it; however, there is no evidence that spasm occurs in patients with claudication. When vasodilator drugs are given orally or intravenously, the vessels in normal vascular beds, which are easily capable of dilatation, will show an increase in blood flow. Unless the cardiac output is increased, the flow to the ischemic limb will not be increased and may actually be reduced."

The saphenous vein bypass from the groin to calf permits revascularization without disturbing the circulation which already exists—implantation of a saphenous vein bypass is comparable to adding a huge collateral. Occlusion of a bypass does not worsen the limb. Thus, bypass is a conservative approach as compared to thromboendarterectomy. Progression of arteriosclerosis usually does not occlude the bypass.

Surgical correction of femoropopliteal occlusive disease was offered to patients whose daily activities at work or leisure were curtailed by claudication. Patients with rest pain were urged to undergo bypass, especially if non-narcotic analgesia failed to relieve pain. Bypass permitted successful toe amputations, which were done in all those with digital gangrene who could be rehabilitated. Hypertension, advanced age, compensated heart disease, and diabetes are not contraindications to bypass. Mortality and morbidity are minimal, probably because dissection is essentially limited to subcutaneous tissue of a limb.

Advanced conditions which limit life expectancy or walking militate against bypass unless major amputation is the only alternative. In this series, a toe amputation together with bypass in a 92-year-old patient restored him to an active self sufficient life. The risk of major amputation is greater than the risk of femoropopliteal bypass and few elderly patients are able to walk after major amputation unless it is done below the knee. Above or below knee amputations are no longer justified for a necrotic toe unless arteriograms have demonstrated occlusion of all major vessels in the lower leg, or no vein suitable for bypass grafting is available.

Summary

In this series, 156 femoropopliteal bypass procedures with saphenous vein had an operative mortality of 1.3%, and patency rate of 98% on discharge from the hospital. The percentage of grafts functioning longer than one year, as determined by the method of Kaplan and Meier, is 84%; above five years it is 65%. Patency rates were not statistically significantly related to clinical and arteriographic severity of ischemia, diameter of grafts or the presence of diabetes.

Arteriosclerosis obliterans is easily diagnosed by typical calf claudication: pain or fatigue in the calf with exercise relieved by a brief rest. The patient is usually a cigarette smoker with segmental occlusion in the aortoiliac or femoropopliteal region.

If obstruction is primarily femoropopliteal there is a satisfactory femoral pulse but no popliteal and pedal pulses.

Vasodilators have not, by well controlled studies, proven of value in the treatment of arteriosclerosis obliterans. In contrast, the bypass procedure using saphenous vein satisfactorily restores arterial circulation. The safety and success of saphenous vein bypass for femoropopliteal atherosclerotic occlusions justify offering the procedure to patients with intermittent claudication as well as those with more severe ischemia.

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ABSTRACTS WISCONSIN NEUROLOGICAL SOCIETY

FROM FALL MEETING—WISCONSIN DELLS, NOVEMBER 11, 1972

Edited by Gastone G. Celesia, MD, Secretary–Treasurer

Diphenylhydantoin: Binding and Toxicity

Harold E. Booker, MD, Madison

While in general there is a correlation between the total concentration of diphenylhydantoin (DPH) in serum and the degree of clinical intoxication, there are frequent exceptions to this general rule. A large portion of DPH binds to serum protein and it is generally considered that only the free or unbound drug concentration is biologically active. It was hypothesized that considerable variance in the degree of protein binding of DPH could occur, and that this difference might explain some of the discrepancies between total DPH serum concentration and clinical intoxication.

The degree of protein binding of DPH was determined by an ultrafiltration technique and DPH concentrations were determined by gas liquid chromatography. The technique is rapid and inexpensive and can be performed by any laboratory which has the capacity to determine DPH concentrations.

Results in 25 subjects support the hypothesis that clinical intoxication is more directly related to the free or unbound DPH level than to the total DPH level. □

Reading Epilepsy in Identical Twins

Francis M. Forster, MD and Richard F. Daly, MD, Madison

Two identical twin sisters, age 29, were studied for reading epilepsy and the identical nature of their twinning was determined. The reading epilepsy was established by AV monitoring of the patients and the EEG in the laboratory. The twins were found to have typical reading epilepsy seizures when reading non-familiar material, whether reading horizontally or vertically, whether reading monocularly or binocularly. Reading memorized material did not evoke seizures. In addition to seizures when reading they also had seizures when writing, even when writing blindfolded. The clinical component was a hand jerk rather than the jaw jerk. Reading musical scores without words also evoked seizures.

These studies further our observations that reading epilepsy is on a higher nervous system level than purely visually induced seizures and should be considered a communication disorder.

The identical nature of twinning was determined by blood typing and fingerprints. The genetic implications of the twin studies were discussed. □

Central Pontine Myelinolysis: A Vascular Syndrome?

Alden W. Dudley, Jr., MD, Thomas Chuprevich, MD, Paul L. Schraeder, MD, and Enrique Sajor, MD, Madison

Perivascular congestion by lymphocytes was observed in the basis pontis of a patient with chronic lymphocytic leukemia and the central pontine myelinolysis (CPM) syndrome. An additional case of the CPM syndrome is an alcoholic who had a cardiac arrest with successful resuscitation and 8 weeks survival seemed to confirm a vascular etiological hypothesis. Review of the literature in regard to the anatomy of pontine arteries and case reports of CPM favors a possibly significant role of the paramedian branches of the basilar artery in the genesis of the CPM syndrome. □

Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Diagnosis and Treatment of Iron-Deficiency Anemia

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Milwaukee, Wisconsin

IRON DEFICIENCY is one of the two most common causes of anemia in the United States and is the leading cause in the world at large. Because it is so prevalent and so readily amenable to seemingly innocuous and easily administered therapy, there is a frequent temptation to treat patients with hypochromic microcytic anemia or anemia of unascribed etiology with a therapeutic trial of iron, perhaps in conjunction with other hematinics.

This may be done with the view that if after an indefinite period of time no response is forthcoming or the anemia recurs, perhaps a more definitive investigation may be undertaken. Although a majority of patients so handled will not suffer any obvious adverse effects and many may have an iron-deficiency state corrected, a very significant percentage will have been denied specific diagnostic elucidation of the underlying cause of their anemia and thus specific therapy. The time lost may be critical.

Considering the rather simple determinations available to screen for iron deficiency and the serious implications inherent in this diagnosis, the trial and error approach to patients with anemia is not justified.

Iron deficiency not a primary diagnosis

The point cannot be stressed too strongly that the administration of therapeutic iron treats the consequence and not the fundamental cause of iron deficiency. The iron-deficient state is the result of either inadequate intestinal absorption of iron, the excessive loss of iron from the body or a combination of both factors.

Although inadequate absorption due to inadequate oral intake of iron is the major cause of iron deficiency during the growth period of the first two decades of life and in the pregnant woman, iron deficiency in the adult is most often the consequence of blood loss. Except during menstruation and

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pregnancy, the ability of the body to rid itself of iron is exceedingly limited, amounting to less than 1.0 mg daily, largely in desquamated intestinal epithelial cells and in negligible amounts in urine, sweat, and desquamated skin. This loss is balanced by the intestinal absorption of ingested iron.

Even with heavy overload, the natural excretion of iron is maximally 2.0 or 3.0 mg per day. Therefore, the adult man and nonpregnant woman can lose significant amounts of body iron only with blood loss.

The total body iron content is dependent upon the size, age, and sex of the individual. The bulk of the iron is incorporated into hemoglobin where it remains for the life of the red cell. The iron content of blood is 3.4 mg of iron per 500 ml of whole blood. This represents a total of approximately 2.5 gm of iron in a 70-kg man. About 21 mg of this iron are released daily from the breakdown of senile red cells within the reticuloendothelial system, with an equal amount being utilized daily for hematopoiesis.

As only about 1.0 mg of new iron is absorbed each day, it can be seen that normally nearly 95% of iron required for hematopoiesis is derived from recycled iron. Another 15 mg of body iron are bound to heme iron in myoglobin and tissue enzymes, only 0.4 mg are present in serum bound to transferrin, and the remainder is present in the iron stores as hemosiderin or ferritin and is largely concentrated in the reticuloendothelial cells of the bone marrow, liver, and spleen.

In the adult man iron stores approach 1.0 gm while the average woman maintains estimated stores of 200 to 400 mg. Unfortunately, the precise clinical determination of iron stores in the living host is not as yet possible but must be inferred by indirect means. However, iron-deficiency anemia itself does not occur until the available stores are exhausted.

TABLE 1—*Causes of Iron Deficiency*

I. Inadequate absorption of iron:
- A. Inadequate intake of iron
- B. Malabsorption of iron
  1. Unabsorbable forms of iron
  2. Bypass of major absorptive site (duodenum); i.e., Billroth II gastrectomy with gastrojejunostomy
  3. Inflammatory small bowel disease and/or rapid transit syndromes

II. Increased physiologic requirements:
- A. Growth
- B. Menstruation
- C. Pregnancy
- D. Lactation
- E. Erythrocytosis

III. Accelerated loss:
- A. Overt (epistaxis, hemoptysis, vaginal bleeding, gross hematuria, hematemesis, melena or rectal bleeding, traumatic blood loss, frequent venoclysis for diagnosis, blood donation or therapeutic phlebotomy, hemodialysis).
- B. Occult
  1. Gastrointestinal blood loss
  2. Idiopathic pulmonary hemosiderosis and Goodpasture's syndrome
  3. Chronic hemoglobinuria and hemosiderinuria; i.e., paroxysmal nocturnal hemoglobinuria.

Causes of iron deficiency

The principal causes of iron deficiency are outlined in Table 1. The malabsorption of iron as a cause of anemia is rare and when present is usually but one of several factors in the etiology of iron deficiency. Achlorhydria has not been clearly demonstrated as a cause of iron deficiency due to malabsorption in man. Severe chronic iron deficiency itself may result in decreased acid and intrinsic factor production by the stomach.

The poor iron content of milk can lead to dietary iron deficiency in the infant, but it can be prevented by supplementation with iron-containing foods or pediatric iron preparations at an early age.[1] The average American diet, with its emphasis on meat, vegetables, and iron-fortified grain products, in general does provide an adequate source of iron, about 10 to 15 mg daily, of which 10% or 1.0 to 1.5 mg are absorbed, but this may not protect individuals with peculiar or restricted diets such as favored by many adolescents, diet faddists, the elderly, and recluses.

The practice among some segments of the black population of eating cornstarch or clay can contribute to iron deficiency, the former for lack of iron content and the latter through binding otherwise available dietary iron and rendering it unabsorbable. The resultant iron deficiency only makes the craving (pica) for these substances more intense.[2]

The diet in areas of poverty as well as in extensive areas of the world may be deficient in iron. Because a major segment of the world's impoverished high-density populations are children and multiparous women, inadequate intake and increased need frequently are present in the same individuals.

In view of the greater need for iron among certain segments of the American population, the legislated standardized enrichment of bread and cereal products with iron has been proposed and is currently a matter of controversy.[3,4]

Overt blood loss usually poses no problem in diagnosis, but blood donation or frequent diagnostic

venoclysis may escape consideration. Occult gastrointestinal bleeding may pose considerable diagnostic difficulties and unfortunately is a leading cause of iron deficiency in adults. A list of the more common causes are given in Table 2.

The diagnosis of iron deficiency

Iron deficiency can be suspected on the basis of the history and physical examination but requires laboratory confirmation. Mild iron-deficiency anemia and iron deficiency without anemia are generally without symptoms or physical findings. With increasing anemia there is pallor of the skin and mucous membranes and general symptoms secondary to anemia such as dyspnea and palpitations with exertion and ready fatigability.

A generalized tiredness seemingly in excess of the actual hemoglobin deficiency has been suggested to be due to low tissue levels of iron-containing enzymes. In very severe chronic iron deficiency, epithelial findings may be present in the form of glossitis, cheilitis, fragility and spooning of the nails, dysphagia and esophageal webbing (Plummer–Vinson syndrome).

The history of pica or abnormal craving for substances such as starch, clay, ice cubes or other various foodstuffs should alert the physician to the suspicion of iron deficiency.

Of paramount importance is the determination of the complete blood count (CBC) and red cell indices and examination of the peripheral blood film.[5] In moderate to severe anemia, the red cells appear small with narrow rims of hemoglobin and a variable tendency toward poikilocytosis with target cells, ovalocytes, pencil cells, and fragmentation. This morphology is highly suggestive of iron deficiency which is by far its most common cause, but there are other etiologies of hypochromic microcytic anemia from which it must be differentiated (Table 3). On the other hand, a mild degree of hypochromia without poikilocytosis is of uncertain significance.[6]

With the increasing routine use of Coulter counter hemograms and similar automated counting procedures, the red cell indices are automatically calculated and part of the reported CBC. The red cell indices demonstrating a low MCV and MCHC help confirm the visual impression of the hypochromic microcytic state. The reticulocyte count should be done but is usually normal. In the presence of classical hypochromic microcytic anemia with the cause of iron deficiency clinically obvious, further investigation may be unnecessary. In the absence of a definite cause, or with a mild anemia with normal or uncertain morphology, further documentation of iron deficiency must be sought.

The serum iron and total iron binding capacity (TIBC) are relatively simple to perform and the classical pattern of a low serum iron with an elevated TIBC is virtually pathognomonic for iron deficiency. The other causes of hypochromic microcytic anemia all have normal to high serum iron levels without elevation of the TIBC. A low serum iron alone, however, is an inadequate indicator because serum iron level falls with infection, inflammation, malignancy or other chronic diseases. Thus, the anemia of chronic disorders, probably the most common form of anemia in the United States, is characterized by a low serum iron but with a low transferrin level as reflected by the depressed TIBC.

The coexistence of iron deficiency with these other disease states may result in an indefinite serum iron-TIBC pattern and the more direct determination of stainable bone marrow iron may be necessary. The iron-deficiency state without anemia may have normal serum iron-TIBC levels. The latter condition in general escapes clinical detection with currently available diagnostic techniques, but considering that up to 30% of the total body iron could be lost (the potential equivalent of 3 to 4

TABLE 2—*Causes of Gastrointestinal Blood Loss Leading to Iron Deficiency*

1. Hemorrhoids
2. Salicylate ingestion
3. Peptic ulceration
4. Hiatus hernia
5. Diverticuli
6. Malignant lesions, especially carcinomas and lymphomas
7. Polyps
8. Ulcerative colitis
9. Crohn's disease
10. Hemorrhagic gastritis
11. Varices
12. Thrombocytopenia and other coagulopathies
13. Hereditary telangiectasia
14. Hook-worm infestation
15. Meckel's diverticulum
16. Ischemic bowel disease

TABLE 3—*Hypochromic Microcytic Anemias*

1. Iron-deficiency anemia
2. Thalassemia and related syndromes
3. Sideroblastic anemias
4. Congenital atransferrinemia
5. Anemias of chronic disorders*

* May show mild to moderate hypochromic with or without sideroblasts, but most often normochromic normocytic.

units of whole blood) before the above tests become abnormal, some means to discern this early phase of iron deficiency seems important. Unfortunately, the only means commonly available to do this at present is determination of bone marrow content of stainable iron (hemosiderin).

There are serious reservations about the accuracy of quantitating body iron stores by studying a bone marrow aspirate or biopsy, but the total absence of stainable iron strongly suggests iron deficiency whereas its presence in nearly all instances rules this out as the determining cause of anemia.

Since the diagnosis of unexplained iron deficiency implies the need for a systematic search for the cause, with particular attention to the possibility of gastrointestinal blood loss, the determination of bone marrow iron stores may well be worth the effort in judging whether extensive endoscopic and radiologic procedures are indicated.

The measurement of the urinary excretion of chelated iron following use of deferoxamine has not been sufficiently accurate in assessing iron stores in iron-deficiency states.

Recently described is a new technique which may aid the clinician considerably in the detection of iron-deficiency states and may offer a satisfactory alternative to a bone marrow determination of iron stores.[7] The initial results utilizing the urinary excretion of an orally administered dose of cobalt tagged with ^{57}Co have demonstrated increased excretion of ^{57}Co in patients with iron-deficiency anemia or iron-deficient states without anemia whereas patients with other forms of anemia, including anemia of chronic disorders with a low serum iron, had normal excretion levels. Further experience is needed with this test, but it appears very promising at this time.

Current methods of searching for occult blood loss cannot be detailed here, but suffice it to say that a few random stools which are negative for occult blood do not rule out the possibility of previous, intermittent or low-grade blood loss. Patients with previously negative examinations who have recurrence of iron deficiency despite adequate iron therapy may require complete reevaluation of the gastrointestinal tract; the ulcer, polyp or carcinoma which escaped detection on the first examination may be evident upon a repeat study.

Therapy

The treatment of iron deficiency is two-fold. The first is to eliminate or control the cause if possible. The second is to restore the deficient iron. There are three ways to do this: (1) administration of iron by mouth, (2) use of parenteral iron, and (3) use of transfusion of red cells.

The need for blood transfusion should be limited to emergent situations such as hypovolemia, presence or high risk of cerebral or myocardial ischemia, congestive heart failure, compromised pulmonary gas exchange, the need for immediate stressful surgical or diagnostic procedures, and continuing blood loss. Modest exertional dyspnea or a low blood count by themselves are not indications for transfusion and the rapid transfusion of blood, especially whole blood in a patient with chronic blood loss, can be hazardous. Patients with chronic anemia of any cause tend to make metabolic adjustments which in part compensate for decreased hemoglobin values, such as increased red cell levels of 2,3 DPG which results in augmented release of oxygen to the tissues. In any case, the correction of the anemia with transfusion does not correct the tissue or storage iron deficit.

In most cases of iron deficiency, the treatment of choice is the use of oral ferrous iron salts. Dietary sources are too low in iron content to be a practical means of treatment. Many iron preparations are available including timed-release forms and various combinations with other hematinics and with substances considered to enhance absorption. The variety offered and claims made by the manufacturers are bewildering to the physician looking for an ideal agent. In truth, the claims notwithstanding, there are only minor differences in the amount of iron absorbed from the various preparations when compared to the standard ferrous sulfate preparation, whereas the cost may be manyfold greater.[8]

Ferrous sulfate, fumarate, gluconate, succinate, glutamate, and lactate are all more or less equally absorbed. Gastrointestinal distress or intolerance of iron are simply a function of the quantity of iron present rather than its form, although individual idiosyncrasies are occasionally noted. These side effects are often transient but, if persistent, can be eliminated by reducing the dosage.

The addition of very large amounts of ascorbic acid to small amounts of iron may significantly augment iron absorption but the effect of the ascorbic acid in the amount contained in most iron preparations is minimal. The absorption of inorganic iron is only 10 to 30% at best. Thus, the standard tablet of 300 mg of hydrated ferrous sulfate (200 mg dry salt) which contains 56 mg of iron may deliver 5 to 15 mg of absorbed iron. The standard dose of three or four tablets per day is to be given about two hours after meals (but not at the same time as antacids). Larger doses are usually unnecessary, will not further augment the hematologic response and greatly increase the gastrointestinal side effects.

The use of enteric coated tablets and timed release capsules is nonsensical inasmuch as the iron

should be available at the duodenal mucosa for optimal absorption. The release of iron from most of these preparations when incubated in gastric juice is less than 5% at 180 minutes,[9] indicating that the iron is released at a joint beyond where it is effectively absorbed. Various combinations with small amounts of intrinsic factor are valueless since they do not enhance utilization of iron, are inadequate to treat pernicious anemia, and eventually sensitize the host to the animal intrinsic factor protein.

If a patient needs vitamin B_{12}, it should be given parenterally. The use of crude or purified liver extract, administered orally or by injection, was an historically important milestone in therapy but no longer has any place in modern pharmacology with the availability of chemically pure folate and B_{12} preparations.

The therapeutic response to iron therapy can serve as a confirmation of the diagnosis of iron-deficiency anemia. Ordinarily, in the uncomplicated case of iron-deficiency anemia, a reticulocyte peak can be expected on the 7th to 14th day of the therapy, averaging on the 10th day. Because the red blood cell count with hypochromic microcytic anemia may be only minimally depressed, the peak reticulocyte percentage may be fairly modest and easily missed if counts are not done frequently. A slow but steady increase in hemoglobin content of the blood follows the reticulocytosis. The physician expecting dramatic and rapid results may prematurely and incorrectly conclude that a patient is not responding to oral therapy. On the other hand, the lack of any reticulocytosis after two weeks and some hemoglobin rise after four weeks of therapy suggests that (1) the iron is not being absorbed properly, or (2) there is a limiting factor upon hematopoiesis other than iron deficiency such as infection or another deficiency. Reevaluation at that point may be necessary.

The estimated duration of oral therapy can be roughly calculated from the degree of the anemia, but the general rule is to treat until a maximal hematologic response has been achieved and then to continue the therapy for a minimum of several more months to rebuild the iron stores. In the face of continued blood loss, heavy menstrual loss, frequent blood donations or partial malabsorption of dietary iron responsive to inorganic iron, maintenance therapy of one ferrous sulfate tablet or its equivalent can be continued indefinitely. Some authors have suggested that all menstruating women take oral iron routinely until menopause.

The use of parenteral iron in the form of injectable iron-dextran complex (Imferon®) or iron-sorbitol-citrate complex (Jectofer®) in most cases does not offer any therapeutic advantage over the use of oral iron preparations. The hematologic response is no better or faster than with oral iron except in those individuals who have a high level of continuing blood loss, and the cost, the discomfort and inconvenience of multiple intramuscular injections, as well as the possible discoloration of the skin if the material leaks into the subcutaneous tissue, are all serious disadvantages. Intravenous single bolus iron-dextran reduces some of the disadvantages, but there is a small but definite risk of an anaphylactic reaction, which seems to be much greater in patients with diseases such as rheumatoid arthritis. There is also a possibility of chemical thrombophlebitis.

Evidence is available that in some individuals the complexed iron is not necessarily completely available for utilization by hematopoietic cells, especially in patients with chronic diseases. However, there are definite indications for parenteral iron. These are: (1) intolerance of oral iron preparations, (2) proven malabsorption of iron, (3) inability or reluctance of patient to cooperate in long-term oral iron administration, (4) continuous significant blood loss not amenable to medical or surgical correction such as bleeding from inoperable neoplasia or hereditary telangiectasia.

Iron-dextran and iron-sorbitol contain 50 mg of iron per ml. The total amount to be given may be calculated by using the figures provided earlier to estimate amount of iron lacking in hemoglobin and the stores or by utilizing the tables provided by the manufacturer with care not to give any in excess of this amount.

In older children and adults, the daily intramuscular dose for any one injection site is 2 ml for iron-sorbitol, and 2 to 5 ml for iron-dextran with increased chance of discomfort with the larger amount. In all cases where parenteral iron therapy is contemplated, the demonstration of an iron depletion state prior to therapy is imperative, inasmuch as iron so given is more or less trapped indefinitely within the body. Too many patients with anemias of chronic disorders or with conditions such as thalassemia minor receive large amounts of therapeutic iron in the vain hope of improving the anemia when a condition of iron overload already exists.

Ultimately, the therapy of iron deficiency rests upon correction of the cause. Dietary intake should be modified or supplemented to insure adequate iron available for absorption to meet the body's needs. With bleeding, the medical or surgical correction of the underlying problem is the appropriate procedure. Medical regimens including use of salicylates or anticoagulants may have to be modified, if associated with blood loss.

Summary

Iron deficiency, with or without anemia, is always secondary to a fundamental underlying disorder. This may be due to inadequate intake and/or absorption of iron, especially during periods of increased iron utilization, but in the adult is most frequently the result of blood loss. The correct therapy hinges upon the firm establishment of the iron-deficient state, the cause of the deficiency, and the site of the blood loss, if any, with primary emphasis upon correcting the underlying disorder. The correction of the iron-deficient state should utilize the mode of iron therapy which is the simplest, safest, and least expensive and should be adequate to replenish empty iron stores. In the vast majority of patients, oral ferrous salts meet these requirements splendidly. A therapeutic trial, with iron or with "shotgun" hematinic preparations, as the initial approach to the management of the anemic patient is thoughtless, dangerous, and unjustified.

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Carotid Artery Stenosis Associated with Surgery for Coronary Artery Disease

VICTOR M BERNHARD, MD; W DUDLEY JOHNSON, MD; and JON J PETERSON, MD, Milwaukee, Wis: *Arch Surg* 105:837–840 (Dec) 1972

Patients presenting for operative repair of atherosclerotic disease involving any given organ system have a high incidence of significant involvement in other areas. This review deals with 31 patients who presented with severe coronary artery disease requiring myocardial revascularization who, at the same time, had clinical evidence of carotid artery stenosis. These patients present the dilemma of a high risk of coronary complications if subjected to carotid artery surgery first, and the risk of stroke due to impaired cerebral perfusion during cardiopulmonary bypass, if coronary surgery is performed prior to carotid repair.

Analysis of our experience permitted retrospective assignment of our patients to one of three groups. Carotid repair was performed before coronary surgery in 15 patients. Three patients in this group died of myocardial complications after carotid endarterectomy, before coronary surgery could be carried out. Two other patients in this group died following coronary revascularization, one from myocardial infarction and one from ruptured abdominal aortic aneurysm in the early postoperative period. The overall mortality rate was 33.3% for this sub group.

The operative sequence of coronary repair followed by carotid endarterectomy was carried out in one patient, who survived both procedures without complications.

Combined carotid endarterectomy and coronary revascularization was performed as the initial procedure in 15 patients, and as the second procedure after an initial contralateral carotid endarterectomy in a 16th patient. In this combined carotid–coronary surgery group, there was no mortality and minimal morbidity, and no myocardial complications followed this combined surgery.

Cerebral complications were infrequent, and only one mild transient neurologic deficit with complete recovery could be potentially related to cardiopulmonary bypass. Three additional patients developed cerebral complications. One transient attack of cerebral ischemia occurred on the second day following an isolated carotid endarterectomy prior to coronary surgery. There was complete recovery within hours, and immediate cerebral angiography revealed no carotid or intracranial branch vessel abnormality. One patient developed a mild transient neurologic deficit one week after myocardial revascularization due to cerebral embolism associated with a myocardial infarct. The last cerebral complication was a carotid thrombosis which produced severe hemiparesis initially. Immediate reoperation with restoration of cerebral flow resulted in 90% recovery of neurologic function.

Our experience with this combination of cerebral and coronary atherosclerosis is relatively small, and the patient groups are not exactly comparable with regard to severity of coronary or cerebral involvement. However, this experience strongly suggests that simultaneous carotid endarterectomy and coronary revascularization may be the most effective means for avoiding myocardial complications and reducing the potential for neurologic deficits in patients requiring coronary revascularization, who are found to have significant extracranial cerebrovascular insufficiency. □

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*Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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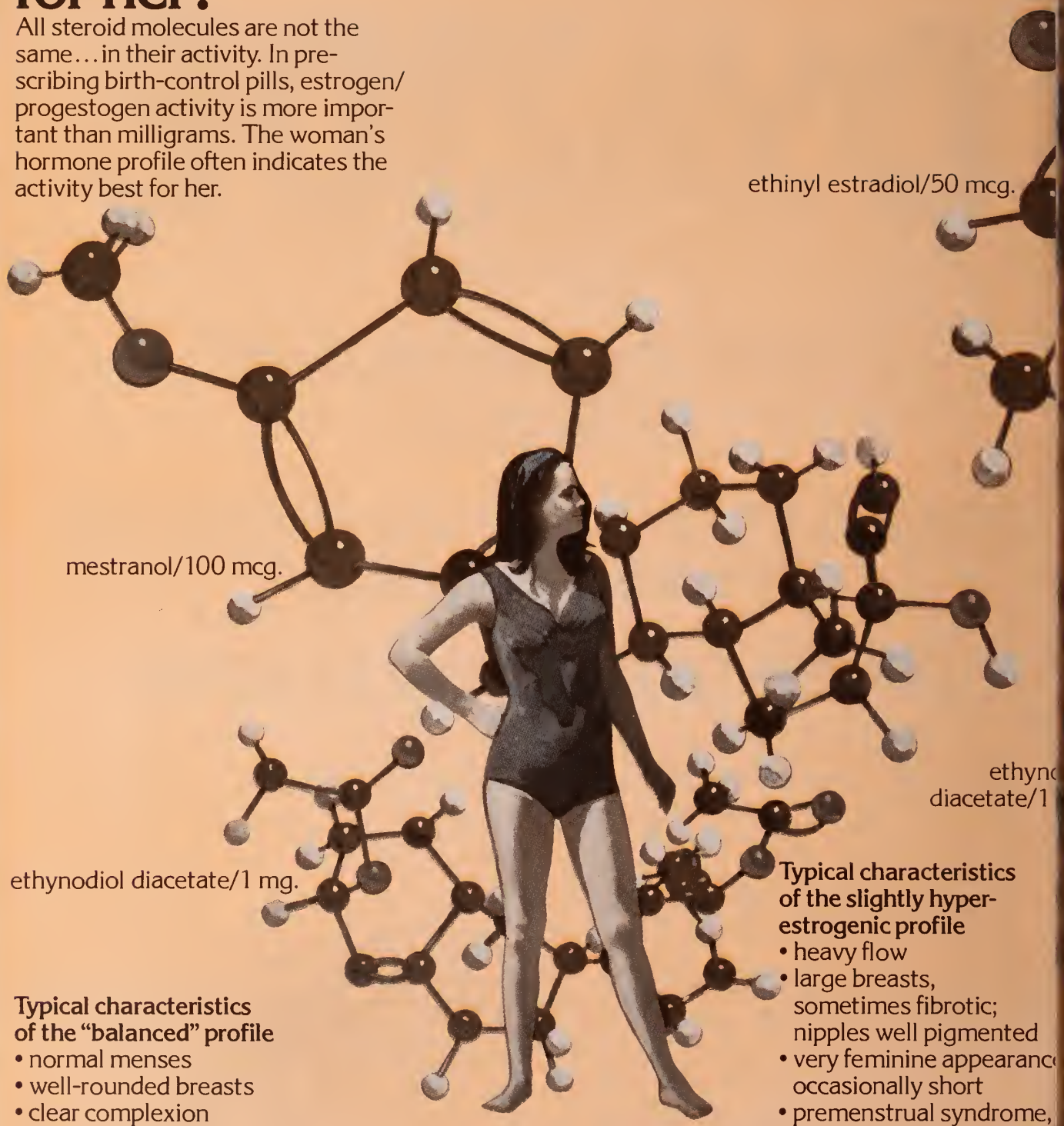

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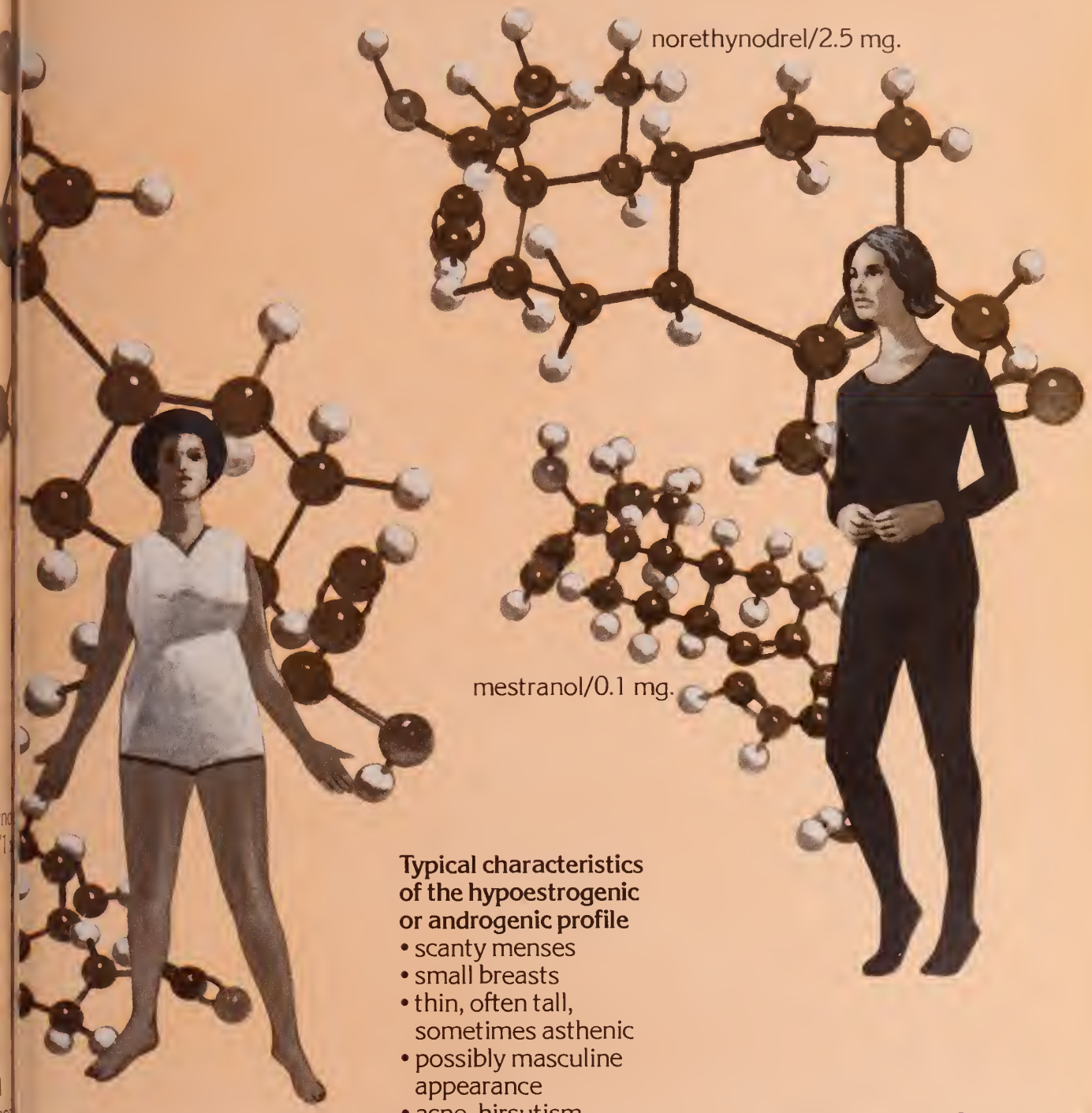
This formulation, which ha less estrogenic activity anc a moderate progestogen dominance, may be a gooc beginning.

For brief summary of prescribing information, please see next page.



Typical characteristics of the hypoestrogenic or androgenic profile

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- small breasts
- thin, often tall, sometimes asthenic
- possibly masculine appearance
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- thin vaginal lining, tendency to vaginitis and dyspareunia

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovari adrenal, hepatic or uterine function awaits further study. A decrease glucose tolerance has been observed in a significant percentage patients on oral contraceptives. The mechanism of this decrease obscure. For this reason, diabetic patients should be carefully observ while receiving Ovulen or Demulen therapy. The age of the patient co stitutes no absolute limiting factor, although treatment with Ovulen Demulen may mask the onset of the climacteric. The pathologist shou be advised of Ovulen or Demulen therapy when relevant specime are submitted. Susceptible women may experience an increase blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral co traceptives—A statistically significant association has been demo strated between use of oral contraceptives and the following serio adverse reactions: thrombophlebitis, pulmonary embolism and ce bral thrombosis.

Although available evidence is suggestive of an association, such relationship has been neither confirmed nor refuted for the followi serious adverse reactions: neuro-ocular lesions, e.g., retinal thro bosis and optic neuritis.

The following adverse reactions are known to occur in patien receiving oral contraceptives: nausea, vomiting, gastrointestinal sym toms (such as abdominal cramps and bloating), breakthrough bleedin spotting, change in menstrual flow, amenorrhea during and after tre ment, edema, chloasma or melasma, breast changes (tenderne enlargement and secretion), change in weight (increase or decreas changes in cervical erosion and cervical secretions, suppression lactation when given immediately post partum, cholestatic jaundic migraine, rash (allergic), rise in blood pressure in susceptible individu and mental depression.

Although the following adverse reactions have been reported users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-li syndrome, changes in libido, changes in appetite, cystitis-like syndrom headache, nervousness, dizziness, fatigue, backache, hirsutism, loss scalp hair, erythema multiforme, erythema nodosum, hemorrhag eruption and itching.

The following laboratory results may be altered by the use of o contraceptives: hepatic function: increased sulfobromophthalein rete tion and other tests; coagulation tests: increase in prothrombin, Facto VII, VIII, IX and X; thyroid function: increase in PBI and butanol extra able protein bound iodine, and decrease in T^3 uptake values; metyrapo test and pregnanediol determination.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* a *Adverse Reactions* listed above for Ovulen and Demulen are applicab to Enovid-E and should be observed when prescribing Enovid-E.

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 4 APRIL 1973

FROM THE PRESIDENT

MINUTEMEN—1973

A departure from principle becomes a precedent for a second; that second for a third . . . —THOMAS JEFFERSON

REFRESHING MEMORIES of our State Medical Society's successful meeting continue to fill my mind and to transfuse me with enthusiasm for the year ahead. A real reawakening and an abounding enthusiasm permeated the participants both in the House of Delegates and in the corridors of the meeting hall. Confidence in the ability of medicine to serve our state's citizenry with quality care at a reasonable cost in the free enterprise system remained paramount among all. This has been and will continue to be our overriding goal in the years ahead. This commitment will remain fixed and to these ends our programs have been directed.

Costs of medical care have been stabilized as witnessed by recent consumer price indices. Medicine's efforts toward this goal have been commendable.

Quality endeavors include a commitment to continuing medical education, health care review, postgraduate membership requirements, support of more and better residency programs, excellence in emergency care programs, the Regional Medical Programs and areawide health planning agencies.

Our further obligations to society under the free enterprise system are being met, namely, (1) to serve all in the area we have the ability to serve; (2) to render service to all on equal terms; (3) to serve without attaching unreasonable conditions to such service.

Our freedom to practice without total regulation is now being threatened. Assembly Bill 489 would inject politics irrevocably into our future. Do we stand idly by and watch the intrusion of oppressive controls and red tape into the health care of our citizens? Will we inform the citizens-at-large in every community so they can see the need to resist unreasonable controls? Will we contact legislators —come to Madison if necessary—to demonstrate the seriousness of our concern for Wisconsin's health future under this proposal? Will we be ready to stand up and be counted on a minute's notice? Our forefathers were!

G. J. Derus M.D.

DOCTOR DERUS TAKES OATH OF OFFICE FROM DOCTOR NORDBY

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ANNUAL MEETING

NEW OFFICERS

Elections Change the Leadership

OPENING HIS TERM as president of the State Medical Society, Gerald J. Derus, MD, Madison, characterized the year ahead of him as "exciting and demanding."

The 115th to hold the presidency, Dr. Derus told the House of Delegates that the times are "exciting because of the challenges open to us and demanding because the leadership in our State Medical Society affairs is being second-guessed and threatened by bureaucrats and health planners who expound a philosophy of impatient idealism."

Over the past year as president-elect, Dr. Derus already has had a good dose of exposure to medicine's challenges and idealistic planners. The opening gambits of the Governor's Task Force legislation and federal PSRO watchdogging have meant meetings with government officials, the AMA and other state medical societies, the state medical leadership, and county societies.

From this activity he generated some suggestions on ways Wisconsin medicine could deal with some of the social problems it faces. In his speech to the House of Delegates (reprinted in full elsewhere in this issue of the *Wisconsin Medical Journal*) he made a number of suggestions, including:

- A Wisconsin Health Corps to supply volunteer physicians to areas of the state where more medical services are needed.
- A system of ombudsmen to serve as an arm of the Grievance Committee to give patients an open communication system into the medical community.
- A study of continuing medical education by representatives of Society committees, state medical educators, and government representatives.

Dr. Derus has added all of this to a schedule that includes deep involvement with the University of Wisconsin's family practice program, an active practice at the Monona Grove Clinic which he founded, and numerous civic and business activities.

He finished medical school in Madison in 1952, began the family practice of medicine in Madison in 1953 and founded the now seven-man Monona Grove Clinic in 1955.

Dr. Derus is immediate past president of the Dane County Medical Society, and former president of the Wisconsin Academy of Family Physicians and its Dane County Chapter. He is a charter member of the American Board of Family Practice. Dr. Derus' biographical sketch appears elsewhere in this issue.

Another family physician is "warming up in the bull pen," as the president-elect's role has been described. The House of Delegates picked John E. Dettmann, MD, Green Bay, to take the top slot next year.

He has headed the Brown County Medical Society and the Northeastern Wisconsin Health Planning Council.

He has served as a member of the State Medical Society's Council from the sixth district since 1966 and was elected vice-chairman of the Council in 1971 and 1972. He also has been serving as chairman of the Council's Finance Committee.

He also has served as a delegate and alternate delegate to the State Medical Society and as a

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

DOCTORS STUFF, NEREIM AND HAMLIN AFTER THE ELECTION

DOCTOR KIMMEY AT SOCIO-ECONOMIC LUNCHEON

member of the State Society's Committee on Cancer.

Dr. Dettmann was born June 2, 1918, in Rock Springs. He is a 1946 graduate of the University of Louisville, Kentucky, Medical School, and has practiced in Green Bay since 1952.

Replacing Dr. Dettmann as sixth district Councilor is John R. McKenzie, Jr., MD, a Neenah radiologist. Daniel K. Schmidt, MD, Milwaukee, was elected vice-chairman of the Council.

For the first time in the 132-year history of the Society, a woman was elected a constitutional officer. Patricia J. Stuff, MD, a Bonduel family physician was elected vice-speaker of the House of Delegates for a one-year term. This means that she can preside over the 142-member group in the absence of the speaker. □

Too Late?

The efforts by organized medicine in the political arena are both "too little and too late," the Governor's new assistant for health told physicians at the State Medical Society's March 26 socio-economic luncheon in Milwaukee.

James Kimmey, MD, MPH, said that medicine's proposals for such innovations as national health insurance and health maintenance organizations would have been effective ten years ago but are not today.

Dr. Kimmey said that now "the decisions that will affect medical practice are no longer in the hands of the physician." Physicians, in trying to deal with this situation, "are being forced to play 'catch up' ball and the results can be frustrating."

One of the products of this situation, according to Dr. Kimmey, is that "a degree of paranoia grasps politicians and physicians alike." Politicians see MDs as being self-protective. Doctors see any health legislation as restrictive.

Dr. Kimmey devoted the major part of his talk to the health services commission, the most controversial recommendation of the Governor's Health Task Force. The idea has been introduced in the Legislature as Assembly Bill 489. It takes a public utility approach to the regulation of health care, an idea the State Medical Society opposes.

However, Dr. Kimmey called the bill "a mild and cooperative approach." He said if the bill is successfully opposed by the State Medical Society and health costs continue to rise, "the next round of legislation will be infinitely more restrictive than this approach."

He said that although this issue is getting the attention now, it is not involved with real health issues.

That was one statement with which most physicians could agree. As immediate past president Robert Purtell, MD pointed out, the State Medical Society agrees with 90 percent of the Governor's Task Force report. However, public attention is being devoted only to the 10 percent the Society opposes. □

Appointments

As one of his initial acts as president, Dr. Gerald J. Derus appointed 29 physicians to six Society committees.

Those appointments (or reappointments) are as follows:

COMMITTEE ON CANCER: Drs. Gail H. Williams, Marshfield; Donald A. Jeffries, Shawano; and John K. Scott, Madison, chairman (reappointment).

COMMITTEE ON GRIEVANCES: Drs. Oscar G. Moland, Augusta; Owen E. Larson, Neenah; Bernhardt E. Stein, Madison; and Henry S. Ashe, Woodruff, chairman.

COMMISSION ON SCIENTIFIC MEDICINE: Drs. Bradley G. Garber, Osseo; Warren J. Holtey, Marshfield; William E. Hein, Monroe; Bruce J. Stoehr, Green Bay; and Sigurd E. Sivertson, chairman (reappointment).

COMMISSION ON HEALTH INFORMATION: Drs. Joseph S. Devitt, Milwaukee, and Clifford A. Olson, Baldwin (reappointments); Robert E. Dedmon, Neenah; Robert G. Hansel, Baraboo, chairman (reappointment).

COMMISSION ON PUBLIC POLICY: Reappointment of Drs. Patrick J. Bates, Eau Claire; Henry A. Peters, Madison (Section on Neurology and Psychiatry); John R. Schroder, Janesville (Section on Pediatrics); Edwin C. Welsh, Milwaukee (Section on Physical Medicine and Rehabilitation). New appointment of Drs. Frederick J. Carpenter, Wauwatosa (Section on Anesthesiology); Elmer E. Johnson, Madison (Section on Ophthalmology); Donald S. Blatnik, Wauwatosa (Section on Otolaryngology); Stanley N. Graven, Madison (Section on Medical Faculties); and Gabriel P. Gerrazzano, Racine (Section on Public Health). Dr. William T. Russell, Sun Prairie, was reappointed chairman.

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION: Drs. Richard F. Barta, Wauwatosa; Fred A. Karsten, Horicon; and Dale V. Moen, Shell Lake, chairman (reappointment). □

HOUSE OF DELEGATES MEETS

THIS ISSUE of the Green Sheet replaces the formal printing of Reports and Proceedings of the Annual Session of the House of Delegates, March 25–27, 1973, due to the great expense involved. Resolutions and reports of the Council, commissions, and committees were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the content of a particular report or resolution.

THE HOUSE DELIBERATED 35 resolutions submitted by county medical societies and one section (names included in parentheses below), as well as reports of officers, the Council, committees, commissions, and divisions of the Society. Refer to the February and March *Green Sheets* for a digest of the resolutions and for details of recommendations from the Council and certain committees. Following is the text of the reference committee reports with indication of action upon their recommendations by the House of Delegates. Notes have been inserted where essential to comprehension of the action:

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● REPORT OF THE PRESIDENT—Your reference committee would first like to recommend that the House pay highest commendation to President Purtell for the outstanding leadership he has provided to Wisconsin medicine during the past year even during the time that he encountered trying personal health circumstances. The example of dedication and forcefulness that he has set should be one adopted by us all. () Action: ADOPTED

● REPORT OF THE PRESIDENT-ELECT—Your reference committee would also recommend acceptance of the report of your President-elect, Gerald J. Derus, MD and specifically suggests that the House of Delegates endorse his proposal to have the Society develop and coordinate meaningful continuing education courses. Appropriate mechanisms should also be developed to provide documentation of the attendance of physicians at these and other postgraduate programs in his membership file and his credentials file at his hospital. () Action: ADOPTED

NOTE: The full text of the address of Doctor Derus appears elsewhere in this issue.

● REPORT OF THE SECRETARY—Next your committee reviewed and recommends acceptance of the report of the Secretary in which he outlined his duties as chief executive officer of the State Medical Society of Wisconsin and all of its divisions, activities, and personnel. The committee feels the House should express its appreciation to Secretary Thayer for his endeavors to meet with component societies during the year and for his efforts in carrying on the functions of the Society in his capacity as its chief executive and general manager. () Action: ADOPTED

● COMMITTEE ON MILITARY MEDICAL SERVICE—It is recommended that the House accept the report of the Committee on Military Medical Services and take cognizance of the many years of devoted service to that committee by Frank L. Weston, MD and the late James M. Sullivan, MD. () Action: ADOPTED

● DIVISION ON AGING—Your reference committee concurs in the Division's recommendation that an educational campaign on driving techniques is the best approach to dealing with problems encountered by the older driver and encourages the Division to continue working on this subject in cooperation with the Commission on Safe Transportation.

The House should also reaffirm its previous position that retirement should not be mandatory at age 65 and that the State of Wisconsin should take the lead in developing flexible retirement programs.

The committee concurs with the Division in urging that the House of Delegates endorse the proposed program of an Institute on Gerontology if there is adequate physician representation from the Society in planning, development, and administration. () Action: ADOPTED

● Division on Alcoholism and Addiction—The committee reviewed the Division's report and feels that specific emphasis should be given to the following recommendations:

Public drunkenness should be removed from the Statutes as a criminal offense and be appropriately treated as a health problem.

Codeine and codeine derivatives should not be available in cough syrups except on a prescription basis.

Your committee notes with disappointment the less than 10 percent response of physicians to the state survey of physicians on drug abuse cases and encourages better cooperation in the future.

The committee also concurs with the position that everyone should have access to detoxification facilities or units for treatment of alcoholism or drug abuse. However, it questions the wisdom of requiring all general hospitals to have this type of service as a condition of licensure, believing that this could lead to unnecessary expense and duplication of facilities. () Action: ADOPTED

Note: See March *Green Sheet* for further details of this Division's recommendations.

● Division on Chest Diseases—The committee recommends acceptance of and agrees in principle with the recommendation calling for repeal of the Free Care Law for treatment of tuberculosis, only when safeguards for the financial status of all patients are secured. () Action: ADOPTED

● Division on Ear, Nose and Throat—The committee concurs with the recommendations of this Division. It asks that the Society formally recommend that, wherever possible, every child 16 years of age or younger be examined by an otologist and an audiologist who holds a certificate of clinical competency from the American Speech and Hearing Association before being fitted with a hearing aid. () Action: ADOPTED

Note: See March *Green Sheet* for further details of this Division's recommendations.

● Resolution T: *Public health legislation related to speech and hearing*—The committee recommends that Resolution T (Marathon) be referred to the Division on Ear, Nose and Throat for further study. () Action: ADOPTED

● Division on Maternal and Child Welfare—The committee reaffirms that any proposed programs, both legislative and otherwise, be brought to this Division for consultation before implementation. The reference committee recommends concurrence with the Division's report as a whole. In particular it agrees with its request that any proposed nurse obstetrical assistant program or nurse clinical assistant program should be presented to the Division for its consideration, review, and judgment prior to implementation of an official program.

The committee feels the House should accept the resolution of the Inter-Organizational Committee on Immunization to the effect that a statewide campaign be initiated to create a favorable atmosphere for immunization programs directed primarily against diphtheria, pertussis, tetanus, and poliomyelitis to protect individuals of all ages.

The committee also recommends that the State Medical Society work through and with the component county medical societies, the Wisconsin Academy of Pediatrics, the Wisconsin Academy of Family Physicians, and the Wisconsin Division of Health to set up a record-keeping system on immunization as part of its efforts toward accomplishing an adequate level of immunization.

In addition the committee recommends that the House support the statement of the Board of Trustees of the AMA on Centralized Community or Regionalized Perinatal Intensive Care Units.

The committee further recommends that the Division's Subcommittee on Maternal Mortality continue to function. () Action: ADOPTED

● Resolution R (Fond du Lac): *Standard forms in practice of obstetrics and pediatrics*—Your reference committee recommends that this resolution be referred to the Society's Division on Maternal and Child Welfare for study and possible implementation. () Action: ADOPTED

● Division on Nervous and Mental Diseases—The committee moves acceptance of this report. () Action: ADOPTED

Note: The Division's report is informational, containing no specific recommendations.

● Division on School Health—Your reference committee concurs with the interpretations of the Division's recommendations by the Governor's Health Planning and Policy Task Force as listed A through H. It further agrees with the need for careful consideration by any new state study group in defining whether the schools will be used as a facility where services can be delivered or whether the schools will not only be the location but through their staffs will be actually delivering services. () Action: ADOPTED

Note: See March *Green Sheet* for details of this Division's recommendations.

● Division on Vision—Your reference committee accepts the report of this Division and concurs with its recommendation that the Society's Commission on Medical Care Plans review with the Section on Ophthalmology the proper basis for remuneration for eye care. The committee also feels the House should concur in the Division's recommendation that the Society oppose any legislation which attempts to change the current statutory definition of optometry in a manner which will not adequately safeguard the public. () Action: ADOPTED

● Council Committee on Peer Review—The reference committee commends this committee on taking the initiative in developing a program to fit the needs of component county societies. The Peer Review Committee should continue to function as the medical component for implementation of peer review under Wisconsin Health Care Review, Inc. The reference committee urges the Peer Review Committee to work with diligence in identifying practice patterns which might merit evaluation so that initial review can be undertaken on a regional or local basis, thus limiting the need for individual case review at the state level. Your reference committee also concurs in the Council's request that

a study of Professional Standards Review Organizations, as embodied in Public Law 92–603, be undertaken to determine how regulations will affect the State Medical Society, county medical societies, and the membership in general. () Action: ADOPTED

● RESOLUTION J (DANE): *Peer Review Committees*—Your reference committee moves adoption of this resolution in its entirety. () Action: ADOPTED

NOTE: See February *Green Sheet.*

● RESOLUTION DD (WAUPACA): *Quality Assurance Program*—The reference committee feels that the concerns expressed in this resolution have been taken into consideration with the organization of Wisconsin Health Care Review, Inc. and need not be adopted. () Action: Resolution REJECTED

● REPORT OF THE COUNCIL, *exclusive of recommendations A, B and C*—Your reference committee recommends acceptance of this report. It urges the special committee appointed by the Council to exercise vigilance in reviewing model programs proposed to implement "Early and Periodic Screening, Diagnosis and Treatment" for all Title XIX (Medicaid) eligible youths ages 20 and under. () Action: ADOPTED

● SUPPLEMENTARY REPORT OF COUNCIL CHAIRMAN—The reference committee accepts this report. It notes the formation of an Ad Hoc Liaison Committee for the purposes of discussing joint practice proposals currently being made by nursing. It also makes special note of the establishment of three-year terms for the members of all Council committees and commissions for orderly review. () Action: ADOPTED

● RESOLUTIONS N (MILWAUKEE) AND O (LANGLADE): *Abortion and Preservation of Human Life*—In 1970 the House of Delegates adopted a position which requested that the law "clearly establish the right of a physician to abort the unquickened product of conception." It is the recommendation of your reference committee that the House not adopt Resolutions N and O at this time, but instead adopt the following substitute resolution:

WHEREAS, Abortion is a medical procedure with valid physical as well as mental health indications; and

WHEREAS, The recent ruling of the United States Supreme Court has substantially nullified Wisconsin law on the subject of abortion; therefore be it

Resolved, That the State Medical Society of Wisconsin support the enactment of appropriate legislation which would acknowledge the right of a physician to perform an abortion and to practice this medical procedure as he must any other medical procedure and to refuse to perform an abortion within the dictates of his own training, experience and conscience; and be it further

Resolved, That such guidelines be developed which will assure that abortions are performed only under proper medical circumstances with adequate provision for safeguarding the health of the patient; and be it further

Resolved, That the State Medical Society reaffirm its opposition to euthanasia as classically defined as "the act or practice of killing individuals that are hopelessly sick or injured for reasons of mercy." [Webster's Seventh New Collegiate Dictionary] () Action: Substitute ADOPTED

● RESOLUTION CC (DOOR–KEWAUNEE): *Removal of eyes donated for transplant surgery by licensed morticians*—Your reference committee recommends referral of this resolution for further study by the Society's Section on Ophthalmology. The committee urges that the Section embark on a program of physician education in connection with the problem of assuring an adequate supply of eyes for transplant surgery and research. () Action: ADOPTED

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● COMMISSION ON SCIENTIFIC MEDICINE—One of its recommendations would add section chairmen or program chairmen of the sections as members of the Commission. Several testified that this might prove cumbersome and suggested that, as an alternative, the section chairmen or program chairmen of the sections be designated as the Subcommittee on Programs of the Commission. Your reference committee concurs in this suggestion. () Action: ADOPTED

NOTE: See March *Green Sheet* for a summary of its recommendations.

● COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—Your reference committee is in agreement with the proposal to provide funds to assist in the establishment of residency training programs in areas of Wisconsin where no such programs now exist, with the qualification that in certain areas the Medical School model will not be appropriate and that programs be so designed as to be compatible with personnel and facilities in the area. () Action: ADOPTED

● COMMITTEE ON CANCER—Your reference committee recommends acceptance of this committee's report with an amendment in one sentence, adding the italicized words: "Fifty-nine (54%) hospitals *in* which *physicians* treat cancer patients have neither a cancer registry nor a tumor board." () Action: ADOPTED

NOTE: The report is informational in nature with no specific recommendations.

● COMMITTEE ON OCCUPATIONAL HEALTH—Your reference committee recommends acceptance of the report and approval of its three recommendations as outlined. () Action: ADOPTED

NOTE: The recommendations relate to a proposal of George A. Hellmuth, MD, that a medical advisory board be created under the Workmen's Compensation Division. For further details, see story in March *Green Sheet,* "Rx for Workmen's Comp."

● SPECIAL COMMITTEE ON SHORTAGE OF PHYSICIANS—Your reference committee agrees in principle with the recommendations of the Special Committee on Shortage of Physicians with the added proviso that the curriculum vitae of physicians recruited through the National Health Services Corps be filed with and reviewed in advance by the State Medical Examining Board. () Action: ADOPTED

NOTE: Specific recommendations of the committee related to: (1) support of Senate Bill 1, 1973 Wisconsin Legislature, and (2) urging the AMA and Congress to

oppose federal health programs which locate physicians and other personnel in an area of a state without an adequate selection process and in virtually total ignorance of the needs and desires of the community.

● COMMISSION ON SAFE TRANSPORTATION; RESOLUTION II—Your reference committee recommends adoption of the report and recommendations of the Commission on Safe Transportation; and further recommends that Resolution II (Douglas) be referred to the AMA delegation. () Action: ADOPTED

NOTE: See March *Green Sheet* for this Commission's recommendations. The resolution requests reactivation of the AMA Committee on Medical Aspects of Automotive Safety.

● COMMISSION ON PUBLIC POLICY; RESOLUTION U—The committee also considered the report and a supplement from the Commission on Public Policy, as well as Resolution U (Rock) dealing with the employment of physicians by hospitals. The supplementary report is a listing of the status of several items of legislation as of March 19, 1973, and is primarily for the information of the House.

Your reference committee recommends adoption of the report of the Commission on Public Policy with an amendment in the item titled "administrative flexibility for Medicaid (Title XIX)" so as to allow Medicaid patients to retain the right to choose the type of delivery unit. () Action: ADOPTED

NOTE: The report contained the legislative objectives of the State Medical Society in the 1973 session, stating its current position on key issues. The item referred to above read: "This will permit the Department of Health and Social Services to pay premiums for insurance and prepaid health care plans, something now prohibited by law. This would allow the state to permit Title XIX patients to become part of experiments such as those in Dane County, Marshfield, Wausau, Stevens Point and Milwaukee."

Your reference committee further recommends that Resolution U not be adopted at this time and that an educational program be undertaken to inform physicians of the need to provide their professional services on a contractual rather than an employee basis. () Action: Resolution REJECTED

● COMMISSION ON HEALTH INFORMATION—Your reference committee also recommends acceptance of the report submitted by the Commission on Health Information. () Action: ADOPTED

NOTE: This report is informational except for a recommendation that the Society pledge financial support (which was authorized by the Council) to a series of color television programs on the world of medicine being produced by the Los Angeles County Medical Association. If sufficient support is secured on a national basis, the series could be made available by the Society to Wisconsin television stations.

● CES FOUNDATION—Your reference committee recommends acceptance of the informational report of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin and commends it to the members of the House for their study. () Action: ADOPTED

● RESOLUTIONS A AND B (FOND DU LAC): *WISPAC/AMPAC*—Your committee next considered Resolutions A and B. With respect to Resolution A, the committee recommends adoption of the first "resolve," which reads: *"Resolved,* That WISPAC inform its members of swing areas in the state and the philosophy of those candidates towards health care;" and recommends further that the second "resolve" be referred to the WISPAC Board.

With respect to Resolution B, again the committee recommends adoption of the first "resolve" which reads: *"Resolved,* That AMPAC inform its members of swing areas in the country and the philosophy of those candidates towards health care;" and further recommends referral of the balance of the resolution to the WISPAC Board. () Action: ADOPTED

● RESOLUTION C (WAUPACA): *Medic-Alert*—Consideration was next given to Resolution C on the subject of Medic-Alert information. Your reference committee, while in sympathy with this resolution, believes that there are other mechanisms to handle medical alert information which has applicability beyond the operation of a motor vehicle. This, coupled with the question of the legality of adding information on a driver's license, leads your reference committee to the recommendation that Resolution C not be adopted. () Action: Resolution REJECTED

● RESOLUTION H (SECTION ON ANESTHESIA): *Accreditation programs for continuing medical education*—Your reference committee is fully in accord with the concept of continuing medical education and realistic accrediting programs. The committee did not have the advantage of hearing from the sponsor of this resolution and recommends that this be referred to the Commission on Scientific Medicine. () Action: ADOPTED

● RESOLUTION L (DANE): *Medical school family practice programs*—This resolution commends the continuing efforts of the two medical schools in Wisconsin, and your reference committee recommends its adoption. () Action: ADOPTED

● RESOLUTION HH (DOUGLAS): *Medical Student Summer Externship Program*—Since this program is under the sponsorship of the Wisconsin Academy of Family Physicians, your reference committee recommends substitute wording of the resolution as follows:

"Resolved, That the State Medical Society of Wisconsin extend its thanks in appreciation to the University of Wisconsin Medical School for its cooperation in support of the Summer Externship Program of the Wisconsin Academy of Family Physicians." () Action: Substitute ADOPTED

● HOUSE OF DELEGATES POLICY—Your committee would recommend that it be the policy of this House that all sponsors of future resolutions and reports appear before the specific reference committee to which they are referred. () Action: ADOPTED

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

● AD HOC COMMITTEE ON DISTRICTING—Although the House directed only a study of the present districting, the report did propose specific redistricting. While your reference committee appreciates the

time and effort expended, it was felt the recommendations did not present a satisfactory solution to this complex problem. Fully realizing there may be inequities in the present system or other alternatives, your reference committee feels more study is required before this matter can be resolved, and recommends it be returned to the Ad Hoc Committee for further consideration. () Action: ADOPTED

● COMMITTEE ON MEDICINE AND RELIGION—There were no specific recommendations requiring action by this House. However, John O. Simenstad, MD and his committee should be commended for their interest, and their efforts in increasing the understanding between clergy and medicine through such mechanisms as the publication of the Medicine and Religion bulletin and the co-sponsorship of related panel discussions. () Action: ADOPTED

● COUNCIL RECOMMENDATION B: *Revision of Constitution and Bylaws*—One of the primary and continuing functions of this reference committee is to review any recommendations which affect the Society's Constitution and Bylaws. The Planning Committee of the Council had been charged with a complete review of this subject in an effort to clarify and update all its provisions, since these documents control the manner in which our State Medical Society functions. Many of the revisions proposed are of a "housekeeping" nature, and the majority were presented last May for final action at this session.

NOTE: This issue of the *Journal* contains a printing of the Constitution and Bylaws with revisions ADOPTED by the House of Delegates acting on the report of the reference committee. Articles II and IX of the Constitution are amended, and there are a number of Bylaw changes, some involving only transfer to a different section. One constitutional amendment, transferring Section 2 of Article IV on honorary membership to Chapter I of the Bylaws, was accepted and approved but must lie over for final action at the 1974 annual session.

● RESOLUTION D (WAUPACA): *Professional liability*—Resolution D recommends the Society sponsor and support legislation similar to that enacted in the State of California. Your reference committee is in favor of this resolution and recommends its acceptance. () Action: ADOPTED

NOTE: See February *Green Sheet*.

● RESOLUTION E (DANE): *Dual membership*—A number of members and delegates spoke to Resolution E. It was pointed out that Wisconsin is one of only six states in which AMA membership is not voluntary. While most of those appearing in open session were not opposed to AMA membership as such, some felt the mandatory requirement should be eliminated. However, after much deliberation your committee felt the many benefits derived from AMA membership outweigh the arguments against it and recommends continuation of the present requirements. Therefore, it is recommended that Resolution E not be adopted. () Action: Resolution REJECTED

● RESOLUTIONS F (LA CROSSE) AND I (DANE): [*F*] *Election of officers and AMA delegates;* [*I*] *Election of officers*—These were considered together since the subjects are related. Again, there were a number of appearances on these two resolutions. Your reference committee feels that in general, Resolution F is the more acceptable of the two, and recommends Resolution I not be adopted. () Action: Resolution I REJECTED

NOTE: The reference committee recommended adoption of Resolution F with certain amendments. However, the Nominating Committee introduced a substitute resolution providing for amendment of Chapter IV, Section 1 of the Bylaws, which was accepted, laid over until the third session, and ADOPTED as follows:

WHEREAS, The election of representatives is fundamental to a democratic organization, and the current system of election of the State Medical Society of Wisconsin officers and delegates to the AMA does not allow ready participation of all members of the Society in the elective process; therefore be it

Resolved, That Section 1 of Chapter IV of the Bylaws be amended to provide as follows:

"The House of Delegates at its *final* meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district, and one delegate representing all of the scientific sections. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at *the next* annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations." (Italicized words reflect the changes).

Add a second paragraph to Section 1 to read:

"The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the vacancy occurs in the representation from the scientific sections, such vacancy shall be filled by ballot of the several section chairmen." Be it further

Resolved, That the slate of candidates obtained at this time be published in the *Journal* of the State Medical Society at least one month before the annual meeting with a brief biographical sketch of each candidate; and be it further

Resolved, That the current practice of open nomination from the floor of the House of Delegates be continued.

() Action: Substitute Resolution F ADOPTED

NOTE: See page 29 reporting election of the 1973 Committee on Nominations to serve again in 1974.

● RESOLUTION G (LA CROSSE): *Member participation in AMA policy decisions*—Your reference committee favors this resolution, realizing the importance of dialogue between the Wisconsin AMA delegation, this House, and the general membership.

Reference Committee on Reports of Officers: Doctors Janssen and Chairman Stuff.

Nominating Committee: (seated, clockwise) Drs. Riesch, Wyman, Taxman, Moore, Picard, Bergwall, Welsch, Tydrich, Strebe, Murphy. Standing, Drs. Simenstad, Senty, Erwin. Because the House voted to have the Nominating Committee meet next year prior to the annual meeting (see page 28), it also reelected this year's Nominating Committee for 1974.

Planning Committee members Doctors Smejkal, Behnke, Lewis, and Chairman Manz

Reference Committee on Reports of Standing Committees

Reference Committee on Reports of Officers: Doctors Costello and Carlson

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws

Reference Committee on Finances

It commends the AMA delegates and alternates for their willingness to hold an annual open hearing. However, the difficulty of rescheduling the state annual meeting to coordinate with that of the AMA should be pointed out. Therefore, your committee recommends adoption of Resolution G, with the deletion of the last resolve. () Action: ADOPTED

● RESOLUTION K (DANE): *Residents, Interns, Medical Students*—Your reference committee is in favor of Resolution K and recommends its adoption. () Action: ADOPTED

NOTE: This establishes a section with voting rights for resident members, and an advisory section for interns and medical students.

● RESOLUTION Q (FOND DU LAC): *Terms of AMA delegates*—Your committee feels there is some merit to the concept of the resolution, but that if other state delegates to the AMA are not so limited in the number of terms they may serve, this could hinder the effectiveness of the Wisconsin delegation. Therefore it is recommended Resolution Q not be adopted. () Action: Resolution REJECTED

● RESOLUTION V (MARINETTE): *Medical student experience in health manpower shortage areas*—Your reference committee felt the intent was commendable, but that implementation of such a program would not be practical. It recommends the resolution not be adopted, but urges the House to again encourage the medical schools to continue efforts to promote interchange between the practicing physician, the academician, and the medical student. () Action: Resolution REJECTED

● RESOLUTION W (GREEN LAKE–WAUSHARA): *Unionization of medical practitioners*—Remarks presented in open hearing left your committee with the impression that the intent of Resolution W was to provide not only a united front, but a greater political and socio-economic thrust, and it felt that these results could be accomplished within our present organizational structure, and the WISPAC–AMPAC organizations. Further, it understands the AMA is presently studying this subject for report to its House in June. It is recommended that any action on this subject be deferred until after that report is available, and that, therefore, the resolution not be adopted. () Action: Resolution REJECTED

● RESOLUTION Y (GREEN LAKE–WAUSHARA): *Periodic licensure re-examination*—Your committee feels that with the advent of the new PSRO law, as well as other review organizations, and the president-elect's suggestion for new and continuing medical education programs, a high level of patient care should be assured. It therefore recommends the resolution not be adopted at this time. () Action: Resolution REJECTED

● RESOLUTION BB (GREEN LAKE–WAUSHARA): *Medicredit*—Your committee is in favor of this resolution, except that it does not feel there should be any fiscal commitment for newspaper advertising. Therefore, it recommends adoption of the resolution, with the following amended resolve:

"*Resolved,* That the State Medical Society of Wisconsin fully supports this particular legislation by contacting our congressional delegation or by whatever other means would make our position as physicians known to the public." () Action: ADOPTED

● RESOLUTION EE (DOUGLAS): *National Health Service*—Your committee is in sympathy with the concern expressed, but feels that since HR 1 is now Public Law 92–603, the resolution is not apropos at this time, and recommends that it not be adopted. () Action: Resolution REJECTED

● RESOLUTION FF (DOUGLAS): *Governor's Health Policy and Planning Task Force report*—It commends the secretary, Mr. Thayer, for his minority report, and recommends acceptance of the resolution. () Action: ADOPTED

● RESOLUTION GG (DOUGLAS): *Preservation of Wisconsin's natural habitat*—Your committee heartily agrees that the resolution should be accepted as presented. () Action: ADOPTED

REFERENCE COMMITTEE ON FINANCES

● TREASURER'S REPORT—Your committee recommends acceptance of the annual report of the Society Treasurer, Frank L. Weston, MD, with commendation to him for his dedicated service, and congratulations on his induction into the esteemed Fifty Year Club. () Action: ADOPTED

● COUNCIL RECOMMENDATION A: *Dues for 1974*—Your committee notes that through the efforts of the Finance Committee of the Council in watching over Society expenditures and careful budgeting, reserves are approaching a prudent level, and it enthusiastically recommends approval of the recommendation that there be no increase in dues for 1974. () Action: ADOPTED

● COUNCIL RECOMMENDATION C: *Separate incorporation of WPS*—Your committee, after careful deliberation of information provided by the Council and supplemented during the open hearing of the reference committee by special counsel, Mr. Richard P. Tinkham, and others, submits the following substitute resolution which modifies the Council recommendation:

Resolved, That the House of Delegates authorize the reorganization of WPS by the Council and its Commission on Medical Care Plans under Chapter 611 of the Statutes as a stock insurance corporation, and the transfer to such corporation of the assets and business of WPS, including the assumption of all WPS liabilities. () Action: Substitute ADOPTED

● COMMISSION ON MEDICAL CARE PLANS: *1972 WPS annual report*—Your committee recommends acceptance of this report with commendation of the Commission; its Chairman, E. M. Dessloch, MD; the Secretary and General Manager, Earl Thayer; and the Executive Director of WPS, Ray Koenig, for effective operation of the Society's insurance activities. () Action: ADOPTED

● RESOLUTION M (MILWAUKEE): *Current Procedural Terminology*—Your committee wishes to note an error in the third whereas, at least in its reference to "the 1969 California CPT." We believe this is intended to mean the California Relative Value Schedule inasmuch as the CPT is a document developed by the AMA.

The reference committee's recommendation to the House is directed to the "Resolve" and we propose amendment of point (1) to insert the words "as soon as feasible" in the second line after the word "system." The resolution would then read:

Resolved, That the State Medical Society of Wisconsin:

(1) Direct WPS and Surgical Care to accept claims for services coded by this system *as soon as feasible* and to indicate to private carriers that this is the only coding system sanctioned by the State Medical Society of Wisconsin.

(2) Encourage all physicians to use CPT in describing their services and actively promote this among state physicians. () Action: ADOPTED

● RESOLUTIONS P (LANGLADE), S (JUNEAU), and Z (GREEN LAKE–WAUSHARA): *Uniform statewide fee schedule*—These resolutions were considered together as all have a comparable intent of establishing a uniform statewide fee schedule. Your committee is sympathetic with the need to improve the rural manpower situation and does support the concept of equal fee for equal service, but primarily on the advice of legal counsel believes that none of these resolutions should be adopted, as recommending the establishment of a uniform fee schedule poses the danger of price fixing. Your committee therefore recommends that Resolutions P, S, and Z be rejected.

NOTE: The reference committee recommendation was amended by a motion from the floor by Doctor Griffin (Juneau), seconded and carried, that Resolution S be adopted. See February *Green Sheet.*

() Action: Resolution S. ADOPTED
() Resolutions P and Z REJECTED

● RESOLUTION X (GREEN LAKE–WAUSHARA): *"The Case for American Medicine"*—Your reference committee understands that this book has already been sent to United States Congressmen by the American Medical Association. The committee therefore recommends that Resolution X not be adopted, but that the House forward a recommendation to the Finance Committee of the Council that if the necessary funds are available, the book be provided to state officers and members of the Wisconsin Legislature. () Action: ADOPTED

● RESOLUTION AA (GREEN LAKE–WAUSHARA) *Title XIX claims handling*—Your reference committee points out that the Title XIX program is administered by the WPS division under contract with the State Department of Health and Social Services, and we understand that the staff is studying means of correcting the reporting deficiencies within the limits of this contract. We therefore recommend that Resolution AA be referred to the Commission on Medical Care Plans for investigation and possible action, and ask that the membership be kept informed. () Action: ADOPTED □

Delegates, Council, CESF Elect Officers

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT: Dr. John E. Dettmann, Green Bay

SPEAKER: Dr. William D. Hamlin, Mineral Point

VICE-SPEAKER: Dr. Patricia J. Stuff, Bonduel

AMA DELEGATES: Drs. William B. Hildebrand, Menasha and Roman E. Galasinski, Milwaukee (both reelected).

AMA ALTERNATE DELEGATES: Drs. William T. Russell, Sun Prairie, and Henry F. Twelmeyer, Wauwatosa.

COUNCILORS: Drs. Eugene J. Nordby, Madison; Richard W. Edwards, Richland Center; Walter F. Smejkal, Manitowoc; Howard Mauthe, Fond du Lac; Paul G. LaBissoniere, Wauwatosa (all reelected). Elected for a first term were Drs. John R. McKenzie, Jr., Neenah, and Gregory Inda, Milwaukee.

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL: Dr. Eugene J. Nordby, Madison (reelected).

COUNCIL VICE-CHAIRMAN: Dr. Daniel K. Schmidt, Milwaukee.

TREASURER OF THE SOCIETY: Dr. Frank L. Weston, Madison (reelected).

ASSISTANT TREASURERS serving the Society, SMS Realty Corporation and WPS: Drs. H. Kent Tenney, Nels A. Hill, John T. Sprague, and Robert A. Sievert, all of Madison (all reelected) and Dr. Max M. Smith, Madison.

WISCONSIN MEDICAL JOURNAL: Editorial Director, Dr. Raymond Headlee, Elm Grove (reelected).

COMMISSION ON STATE DEPARTMENTS: Drs. Thomas W. Tormey, Jr., Madison, general chairman (reelected) and Howard G. Bayley, Beaver Dam, vice-chairman. Chairmen of the Divisions of the Commission on State Departments who were reelected are: Drs. Craig Larson, Milwaukee, aging; Darold A. Treffert, Winnebago, alcoholism and addiction; Henry A. Anderson, Madison, chest diseases; John J. Suits, Marshfield, handicapped children; Henry Veit, Milwaukee, nervous and mental diseases; Paul A. Dudenhoefer, Elm Grove, rehabilitation; J. C. H. Russell, Ft. Atkinson, school health; and George Nadeau, Green Bay, vision. Chairmen elected to their first term are: Drs. John M. Mills, Green Bay, ENT, and David V. Foley, Milwaukee, maternal and child welfare.

The following physicians were reelected to these positions on the Charitable, Educational and Scientific Foundation:

PRESIDENT: Dr. Robert T. Cooney, Portage.

VICE-PRESIDENT: Dr. Robert M. Senty, Sheboygan.

TREASURER: Dr. Leland C. Pomainville, Wisconsin Rapids.

TRUSTEE ON THE EXECUTIVE COMMITTEE: Dr. Elmer P. Rohde, Galesville. □

AWARDS

A Concerned Heart

Mrs. Betty Anick's second life began on October 21, 1968. On that date, she was the recipient of the first heart transplant in the Midwest.

Her first life had started 49 years earlier, but was slowing to a stop because of chronic heart disease. Just a few months after the transplant her new life was well underway.

Today, as the longest surviving woman with a heart transplant, she has given hope to hundreds of other patients about to undergo cardiac surgery.

She knows they are deeply discouraged and desperately frightened as she was over four years ago. By visiting them and talking to them she assists in allaying fears and in encouraging them through one of the most difficult periods of their lives.

She is living proof that what they are seeking can be obtained —a return to a full, active life following heart surgery.

She has involved others in her concern as well. Mrs. Anick was instrumental in founding the Concerned Hearts Club, a group of people who have had open heart surgery. The club is active in helping heart patients and their families and in conducting blood donor drives. Her husband, John, who has a permanent pace-maker, is also a Concerned Hearts member.

Mrs. Anick also has worked as an ambassador of good will for the Wisconsin Heart Association and with the Kidney Foundation to encourage organ donations for transplantation.

Mrs. Anick's motto has been "God spared me because I have work to do."

On March 26, Robert F. Purtell, MD, in one of his last acts as President of the State Medical Society, recognized that good work. Dr. Purtell, who last year underwent open heart surgery himself, awarded her the Presidential Citation. It is one of the highest honors the Society can bestow. □

Elvehjem Lecture

This year's memorial lecture honoring internationally known biochemist and University of Wisconsin President, Conrad A. Elvehjem, PhD, was given by Frederick C. Goetz, MD, professor of medicine at the University of Minnesota Medical School. He spoke on "Diabetes: End-stage as Treated by Transplantation."

The lecture award was presented by Daniel K. Schmidt, MD, Milwaukee, who noted Dr. Elvehjem's contributions to medical science and medical education, which are the reasons for the yearly lecture and award.

Dr. Schmidt is a member of the Executive Committee of the Society's Charitable, Educational and Scientific Foundation which administers the memorial lecture fund. □

Complete Physicians

Receiving the Houghton Award is both an honor and a challenge for a medical student. The two physicians whose names the award bears—J. H. and W. J. Houghton, MDs—were truly "complete physicians."

Dr. John Houghton, a president of the State Medical Society, was a general practitioner in Wisconsin Dells. There he treated, nursed, and chided two generations into health. He founded the Dells Clinic and was quietly involved in all aspects of community life.

As he approached the end of his life he became anxious to find a means through which he could emphasize to future physicians the ideals which he considered to be of the greatest importance to practicing medicine in the community.

As a result of this wish, the Society's Charitable, Educational and Scientific Foundation (CESF) each year makes an award to one senior medical student from each of the state's medical schools. They are chosen not only for their high scholastic honors but also because they have demonstrated their ability to work well with and lead their peers.

The fund was augmented by Dr. Houghton's brother, William Houghton, MD, a Milwaukee surgeon.

This year's recipients of the awards were Ted P. Bronson of the University of Wisconsin Medical School and Michael Krentz of the Medical College of Wisconsin.

The awards were made by CESF president, Robert T. Cooney, MD, Portage, during the State Medical Society's awards program March 24 in Milwaukee.

They consist of $100 and a plaque inscribed to the recipient "who, through scholastic excellence, extracurricular achievement and interest in medical organization shows high promise of becoming a complete physician." □

Civic Leadership

As a civic leader, his qualifications are impeccable. George A. Behnke, MD has worked long for both his profession and his community.

His State Medical Society posts include the presidency, vice-speaker, and speaker of the House of Delegates. In Kaukauna and Outagamie County he has held offices in the Junior Chamber of Commerce, the Rotary Club, the Wisconsin Heart Association, the March of Dimes, and the Board of Education. He has been Kaukauna City Health Officer since 1955.

During the last year he has combined his profession and community interests in a unique way. He has headed WISPAC, the Wisconsin Physicians Political Action Committee, since its reorganization a year ago. WISPAC works for good government by supporting candidates for office. Under Doctor Behnke's chairmanship, WISPAC membership has increased geometrically.

As E. J. Nordby, MD, chairman of the Council said in presenting it, the Civic Leadership Award is an apt tribute to the many ways Doctor Benhke has served as a physican and citizen. □

ederick C. Goetz, MD, Minneapolis, Minn. re-ives Elvehjem Award from D. K. Schmidt, MD

Doctor Bernhart receives AMA delegation award from Doctor Galasinski

Houghton Award recipients Ted Bronson and Michael Krentz

John Bell, MD, presents Interstate Postgraduate Teaching Award to Albert G. Schutte, MD, for his long service at the Medical College of Wisconsin

E. M. Dessloch, MD, with CESF award

John and Betty Anick — Mrs. Anick received the Presidential Citation from outgoing President Purtell

J. M. B. Bloodworth, MD, presents award at first Barbara Scott Maroney Memorial Lecture to Paul E. Lacey, MD, St. Louis, Mo.

Leland Pomainville, MD, presents Beaumont lecture award to Walter Ballinger, MD, St. Louis, Mo.

Doctor and Mrs. George Behnke with Civic Leadership Award

Good Neighbor

Eli M. Dessloch, MD, has been both a parent and a good neighbor to the Museum of Medical Progress in Prairie du Chien.

He was on the scene back in 1943 when physicians first became involved in efforts to restore Fort Crawford Hospital, where Dr. William Beaumont did his watershed physiology experiments on "the man with a hole in his stomach."

He headed a group of Crawford County physicians who worked with the Dr. William Beaumont Memorial Foundation, organized to make the hospital into a museum.

As the years passed and the Beaumont Foundation's concerns became those of the Society's Charitable, Educational and Scientific Foundation (CESF), Dr. Dessloch kept working to make the museum a reality.

In 1957 he and William D. Stovall, MD, successfully urged CESF to purchase property adjoining the hospital for the museum site. That year CESF started a campaign to raise money to build the museum.

In 1960, with the money raised, Dr. Dessloch became a charter member of CESF's Permanent Commission on Restoration of Fort Crawford. He continues today as a member of the Permanent Commission of the Museum of Medical Progress. He saw the museum open that year and the Stovall Hall of Health follow two years later.

Over the past decade, Dr. Dessloch has taken a neighborly interest in the museum, just a block from his home and office. He has anxiously checked for wind and water damage after storms and floods and has been on hand for most of the dedications and other events held on the property.

When CESF met during the Annual Meeting last month, they gave Dr. Dessloch the Foundation award in appreciation for his years of work. Although technically it is the CESF award, in Dr. Dessloch's case, it is a combination good neighbor and outstanding parent award. □

Beaumont Lecture

Each year a lecture award honors pioneer physician William Beaumont, MD, whose work on "the man with the hole in his stomach" (actually a gastric fistula) laid the groundwork for our knowledge of the digestive system.

This year the memorial lecture was given by Walter F. Ballinger, MD, Bixby professor and chairman of the Department of Surgery at Washington University School of Medicine. He spoke on "Surgical Management of Endocrine and Exocrine Lesions of the Pancreas."

In making the award, Leland C. Pomainville, MD, Wisconsin Rapids, recalled Dr. Beaumont's experiments at Fort Crawford in Prairie du Chien. Among other things, Dr. Beaumont studied various types of food as they were digested and studied the stomach in relation to the weather.

The book resulting from his labors, *Experiments and Observations on the Gastric Juice and the Physiology of Digestion,* is still an authoritative text on the subject.

Dr. Pomainville is treasurer and a trustee of the Society's Charitable, Educational and Scientific Foundation which administers the memorial lecture fund. □

Tribute to Sarah

Familiarly known by his close friends as "Sarah," Ervin L. Bernhart, MD, Milwaukee, has given much and long to all facets of organized medicine.

Within the State Medical Society he has served as president, twelfth district councilor, member of the House of Delegates, president of the Charitable, Educational and Scientific Foundation, member of the Commission on Medical Care Plans, and delegate and alternate delegate to the American Medical Association.

Special tribute was paid March 24 to his AMA service, stretching from 1956 until 1970. The Society's AMA delegation gave him its first special commendation award.

In presenting it, delegation head and long-time friend, Roman E. Galasinski, MD, Milwaukee, recalled many occasions, both public and private, with Dr. Bernhart.

Dr. Bernhart's many activities—including his terms as head of the Wisconsin Academy of Family Physicians, the board of Surgical Care–Blue Shield and the Medical Society of Milwaukee County—have been acknowledged many times by many groups.

A special resolution adopted in his honor by the Society's House of Delegates at the 1970 Annual Meeting thanked him "with deepest appreciation . . . for these many years of faithful and effective service." It noted that "throughout the past many years, Dr. Ervin L. Bernhart has unstintingly given of his time and energy to promote the public interest in medical and health affairs." □

Reference Committee Members

Reports of Officers

Drs. Patricia J. Stuff, Bonduel, Chm
L. L. Thompson, Green Bay
A. C. Costello, Milwaukee
D. J. Carlson, Milwaukee
M. L. Janssen, Adams

Reports of Standing Committees

Drs. J. K. Scott, Madison, Chm
DeLore Williams, Milwaukee
Henry S. Ashe, Woodruff
M. F. Purdy, Janesville
A. J. Sanfelippo, Milwaukee

Resolutions and Amendments to the Constitution and Bylaws

Drs. T. J. Foley, Milwaukee, Chm
J. J. Tydrich, Richland Center
F. M. Bannister, Chetek
R. D. Heinen, Oconto Falls
George V. Murphy, Milwaukee

Finances

Drs. A. H. Stahmer, Wausau, Chm
W. E. Wright, Mondovi
P. G. LaBissoniere, Milwaukee
D. B. Comin, La Crosse
P. O. Simenstad, Madison

THE NEW PRESIDENT

GERALD J. DERUS, MD

■ Doctor Gerald J. Derus, a very active family physician, who has practiced in the Madison area since 1953, took office as the 118th President of the State Medical Society of Wisconsin during its Annual Meeting March 25–27 in Milwaukee. ■ Born on July 21, 1926 in Kaukauna, Wisconsin, Doctor Derus received his medical degree from the University of Wisconsin Medical School in 1952. His internship was served at St. Mary's Hospital in Madison. Shortly after starting in private practice, Doctor Derus founded the Monona Grove Clinic (1955). The clinic has grown to a point where there are now seven physicians on the staff. ■ As a member of the Society's Commission on Scientific Medicine, from 1967 to 1972, he devoted many hours to the continuing educational programs of the Society. He served his final year as Chairman of the Commission. Doctor Derus extended his interest in continuing education by accepting an appointment as Assistant Clinical Professor of Pediatrics at the University of Wisconsin Medical School in 1969. He recently has accepted a second appointment as Assistant Clinical Professor of Family Medicine. He has played an active part in the establishment of the Family Practice Program at the UW. ■ Doctor Derus is a former president of the Dane County Chapter of the Wisconsin Academy of Family Physicians and also of the Wisconsin Academy of Family Physicians, as well as Immediate Past President of the Dane County Medical Society. Doctor Derus is also a member of the American and Wisconsin Academies of Family Physicians and the American Medical Association. Among the doctor's highest honors is being a charter member of the American Board of Family Practice. Hospital affiliations include all three hospitals in Madison—St. Mary's Medical Center, Methodist Hospital, and Madison General Hospital. ■ Doctor Derus and his wife Betty reside in Monona with their six children: Gail 22, Steve 20, Kevin 18, Alan 17, Michael 16, and Jeff 14. □

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E. Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1972. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., and Employees' Pension Plan and Trust Agreement. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin

BALANCE SHEET
December 31, 1972

ASSETS

Current Assets		
Cash		$ 44,200.00
Accounts Receivable—General		15,377.04
Due from Employees		1,006.41
Due from Charitable, Educational and Scientific Foundation Incorporated		4,833.65
Due from SMS Realty Corporation		13,254.55
Due from Wisconsin Medical Journal	$53,846.71	
Investment in Wisconsin Medical Journal (Deficit)	(41,884.24)	11,962.47
Due from Wisconsin Physicians Service		23,456.16
Due from Employees' Pension Plan		74.00
Due from Other Divisions and Related Organizations for Accrued Payroll and Vacation Pay		229,895.23
Certificates of Deposit		170,000.00
Common Stock		8,361.52
Accrued Interest Receivable		1,101.39
Dividends Receivable		30.75
Guarantee Deposit		425.00
Unexpired Insurance		1,683.41
Total Current Assets		$525,661.58
Fixed Assets		
Furniture and Equipment	$42,985.54	
Less: Accumulated Depreciation	34,214.39	
Total Fixed Assets		8,771.15
Prepaid Expenses and Deferred Charges		
Prepaid Postage and Deposits	$ 6,760.49	
Inventory of Forms and Office Supplies	5,881.48	
Other Deferred Expense	3,785.83	
Total Prepaid Expenses and Deferred Charges		16,427.80
TOTAL ASSETS		$550,860.53

LIABILITIES AND CAPITAL

Current Liabilities		
Accounts Payable		$ 26,646.27
Dues Held for Section on Ophthalmology		8,155.03
Accrued Payroll Taxes		16,862.42
Other Payroll Deductions		2,111.56
Accrued Employee Pension Plan Contributions		1,372.69
Unallocated Dues		286.25
Accrued Property Taxes		10,084.82
Accrued Payroll and Vacation Pay		248,039.26
Total Current Liabilities		$313,558.30
Deferred Income		
Prepaid Membership Dues	$62,910.00	
Other Prepaid Income	9,700.00	
Total Deferred Income		72,610.00
TOTAL LIABILITIES		$386,168.30
Net Worth		
Capital of General Fund 1/1/72	$74,471.22	
Excess—Income Over Expense—1972 Regular Operations	66,215.67	
Excess—Income Over Expense—1972 Special Assessment	34,415.25	
Decrease in Capital Invested in Wisconsin Medical Journal	(10,409.91)	
Total Capital 12/31/72		164,692.23
TOTAL LIABILITIES AND CAPITAL		$550,860.53

NOTES:

(1) Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.

(2) The interest in SMS Realty Corporation is not carried as an asset of the General Fund.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1972

	Special Assessment	Regular Operations
INCOME		
Members 1972 Dues	$	$568,619.50
Less: Allocation to Wisconsin Medical Journal		19,700.00
Subtotal		$548,919.50
Special Assessment Income	39,850.00	
Members Dues—Prior Years		1,969.50
Dues—Academy of Medical History		1,040.00
Annual Meeting		20,976.89
Administrative Services		8,151.15
Miscellaneous Income		389.81
Income on Funds Invested		10,574.10
Gain on Sale of Fixed Assets		9.00
TOTAL INCOME	$39,850.00	$592,029.95
EXPENSES		
Payroll	$	$230,944.58
Payroll Related Costs		35,321.63
President and President-Elect Expenses		3,954.87
AMA Annual, Clinical and Special Meetings		11,800.00
Conference Expenses	23.80	17,746.67
Association Dues		2,622.68
Staff Travel	56.00	24,478.82
Telephone	10.09	9,302.01
Resource Material	37.00	1,431.23
Printing and Forms	1,768.58	16,707.25
Postage	1,327.93	20,085.94
Office Supplies	192.35	5,127.63
Promotion		11,298.21
Insurance—General		3,879.30
Grants and Appropriations		8,312.50
Cafeteria Expense		1,973.34
Speakers Expense		3,321.52
Outside Services	692.00	21,077.38
Miscellaneous Expense		3,600.63
Auditing and Accounting Services		3,668.96
Legal Counsel	1,327.00	22,225.69
SMS Legislative Retainer		14,300.00
Consultation Services		450.00
Depreciation		2,157.89
Rent—Central Office		48,485.32
Rental of Equipment		3,548.63
Meeting Room Rental		118.60
Equipment Repair and Maintenance		668.13
Personal Property Tax		655.52
Christmas Card Expense		1,595.54
Total	$ 5,434.75	$530,741.87
Less: Portion of Above Expenses Recovered by Services Furnished to Others	$	$ 4,927.59
TOTAL EXPENSES	$ 5,434.75	$525,814.28
Excess—Income Over Expenses	$34,415.25	$ 66,215.67

NOTES:

(1) The above excess of income over expense for 1972 is closed to the Net Worth accounts as follows:

	Special Assessment	Regular Operations
To Capital Surplus	$	$ 2,265.96
To Unappropriated Surplus		64,237.16
Total—General		66,503.12
To Academy of Medical History		(287.45)
To Reserve for Special Assessment	34,415.25	
Totals	$34,415.25	$ 66,215.67

(2) During the 1972 Annual Meeting of the State Medical Society of Wisconsin the House of Delegates passed a resolution adopting a one-time special assessment of $10, to finance a campaign to inform the public of chiropractic's threat to good health care of Wisconsin citizens.

The above Statement of Income and Expense reports separately the income derived from the special assessment and expenses attributable to it. It is anticipated that there will be additional expenses attributable to this special assessment and therefore a portion of the net worth of the State Medical Society has been reserved for these anticipated expenses.

PRESIDENT'S MESSAGE TO THE HOUSE OF DELEGATES

GERALD J. DERUS, MD
Madison, Wisconsin

BEING ELECTED one year ago by you—the leaders of our Medical Society—has given me a special opportunity to study and review the responsibility bestowed upon all of us by the title "Doctor of Medicine." It presented to me the privilege of viewing the efforts of our devoted staff, hard working committees, and knowledgeable Council. We also owe our appreciation and thanks to Doctor Robert Purtell, who has proven to be an outstanding leader this past year. His personal dedication to our affairs is an example to all of us. His counsel, in the year ahead, will be an asset to us as we move forward.

This year of observation and study has been thought-provoking, and the conclusions are profound. These are exciting and demanding times. Exciting because of the challenges open to us and demanding because the leadership in our State Medical Society affairs is being second-guessed and threatened by bureaucrats and health planners who expound a philosophy of impatient idealism.

Following the annual meeting last year, your Executive Secretary, along with the Council and the President, reviewed the goals of the State Medical Society for the year 1972–1973. These seemed simple and forthright—primarily related to the areas of education, public affairs, socio–economic issues of medicine, and in the area of organization and administration.

The year 1972 thrust upon us many important and complex issues from within and without our organization. These issues will shape our medical future and force us to react in the years that lie ahead. The challenges relate to our Governor's Health Planning and Policy Task Force and Federal programs related to PSRO or NHI (professional standards review organization or national health insurance). It would be redundant to devote considerable time to these very important issues—you have been well appraised of these programs.

Continuing to be well educated and informed on the various issues and recommendations of the Task Force will continue to consume our time and efforts. I should mention that the Medical Society, through its hard working committees, has played a key role in the formulation of many of these recommendations and has cooperated in their implementation. Our Medical Society can agree with approximately 90% of the recommendations of the Governor's Task Force, but certainly it would be shortsighted of me to say that we agree with the public utility concept of medicine. Your leaders have appeared, at the legislative committee hearings, in Madison in recent weeks and have expressed organized medicine's views on this matter. Suffice to say at this time, I feel it is our responsibility to support and reinforce the competence, integrity, and proper motivation of Wisconsin physicians rather than to transfer their responsibility to the state—leaving them as technicians in a public utility. Dramatic gains in health and medical care have come primarily through private medicine—not from government-operated systems.

An item of equal importance occurred in late 1972 with the passage of the Professional Standards Review Organization legislation which occurred under Public Law 92–603, the Social Security Amendment. This bill will have far-reaching effects on all of us. It is up to medicine working in a partnership with government to set standards of medical care in this country. This will be challenging. Wisconsin Health Care Review Incorporated, which was founded by the medical, dental, and hospital groups, is geared to do a very effective job.

It is refreshing to realize that the Federal government has agreed with medicine that the quality of care, cost audits, and certain control measures are necessary. It is worthy of note that they too have the conviction, as do the majority of physicians, that the appropriateness of physicians' services and the justifications of their fees can be evaluated only by other physicians with comparable training and experience. It cannot be done by insurance adjusters, consumer groups, or county commissioners.

In fact, it cannot even be done equitably by physicians unschooled in the kind of service in question. The challenge that the Federal government has thrust upon us is of immense importance to all. I would urge each county society, councilor district, or area that you might determine, to enter into a relationship with Wisconsin Health Care Review as

Presented before the House of Delegates of the State Medical Society of Wisconsin at the 132nd Annual Meeting, March 25, 1973, Milwaukee.

proposed in one of the resolutions presented to our State Medical Society this year. It is of utmost importance that we take the lead which has been afforded us. This task is immense and important and I am certain we will accept the responsibility.

The third challenge important to us is the movement toward national health insurance. We must remain knowledgeable of the proposals that are before Congress. You and I know that national health insurance will not be a panacea for all of society's health needs, nor will it be the answer to our rising costs relating to our delivery system. Rising quality of medical care inevitably leads to increased demand and therefore higher prices. Government programs lead to increased confusion, decreased efficiency, skyrocketing costs, and more centralized control of our citizens and providers. The change that results does not necessarily mean progress. We must reaffirm the right and capacity of individuals to chart their own future. Your knowledge of these issues and related items are of high priority during the forthcoming year. Your officers and staff will continue to inquire, advocate, and communicate to you through our present channels. We welcome your suggestions. Let us be vigilant—let us not slide down the easy slope offered by the course of events and be dull to our danger.

My view of Wisconsin medicine, during this past year, has been one of satisfaction. We have a vigorous, viable, voluntary organization striving to overcome apathy and to maintain a leadership role. This we have done. I am convinced that the overwhelming numbers of physicians are competent, well motivated, and endowed with integrity. With these qualities, leadership will continue to be ours. Leadership means caring for people in a time of need.

Leadership means preserving and guarding the human resources of this country. Leadership means guiding in the area of continuing medical education, and our advice is continually sought as leaders of medicine in areas involving government and governmental research. We are the leaders in insurance experimentation. Our medical auxiliary has been the leader in many programs that are innovative in the State of Wisconsin and in the nation. We are leaders in the Federal programs relating to Medicaid and Medicare. Many innovative legislative proposals are the result of our direct leadership. Health Maintenance Programs are being carried out with private leadership. We have led in proposing innovative ideas in the health insurance field—such as insurance for the unemployed and the uninsurable in the State of Wisconsin. For years, we have taken leadership roles in maternity and child welfare, mental health, and education of the public relating to health care practices. Our parent organization, the AMA, leads in areas of research, education, and publication. Every segment of Wisconsin society and the patients we serve is touched by our commitment to service.

In spite of these accomplishments in the areas of medical leadership—or maybe because of the accomplishments in these areas—our critics advise us that we have shortcomings particularly in our delivery system. The Governor's Health Planning and Policy Task Force traveled throughout the state and listened to approximately 200 witnesses. These citizens testified to our shortcomings in two areas—namely, the cost of medical care is too high and services are inaccessible to certain people in Wisconsin. These problems are our challenges. Politicians and health planners should realize that if *more* care is to be given to *more* people, by *more* physicians in better equipped facilities, utilizing the ever-increasing numbers of new and more sophisticated and generally more expensive techniques of diagnosis and treatment to achieve earlier diagnosis and afford long and often more expensive survival, the cost for the average family will continue to go up. These factors, plus inflation and labor costs, will also affect the rise in prices. And, if one additionally needs to maintain a massive new bureaucracy to prebudget, monitor, audit, negotiate, review, and administer nationally, regionally and locally, the sky is the limit.

Medicine has cooperated, as you know, in holding the cost of our services at a minimum. During the past year, our fees have risen approximately 2.1%. We know that we are doing our best to "hold the line," but we can and we will do more. We will continue to be more efficient. We will continue to work longer hours. We will continue to experiment with new delivery systems, and be attentive to the overall good management principles that are the hallmark of the free enterprise system. Private business opportunities, in the area of medical practice, must not perish. Existing financial barriers affecting access to health care will continue to get top priority by all interested parties.

Lack of availability of services is evident in some areas of our state. We must share part of the guilt that is society's. We have advocated for years an increase in manpower production at the two Wisconsin medical schools. We have advocated increased Family Medicine as a viable entity and have supported public programs to cure the shortage of physicians by licensing physician's assistants. These measures have been insufficient in scope and implementation. I have given considerable thought to this. It seems paradoxical that the medical profession can have hundreds of volunteers go to Nicaragua and to Vietnam with others volunteering for the Peace Corps and missionary organizations and yet not serving our own state needs. It would seem appropriate that a partnership should be formed between state government and the State Medical Society of Wisconsin in what could be called the Wisconsin Health Corps. This partnership would supply volunteer coverage in the areas of the state which in the opinion of the government and private sector of medicine are in need of increased medical services.

I wonder if this is worth our consideration and action?

Aside from the previous discussions related above, I would like to share with you some thoughts about our Medical Society in the year ahead. Although our activities are the results of many internal and external factors and pressures, our overall goal should be to strengthen our present internal organization. Strengthening these areas is of great concern to me. These forthcoming ideas would by their substance and intent be considered by the appropriate body within the society—

(1) Our staff strength must be increased with an effort to enhance our public relations efforts. Therefore, a new person with public relations experience would be very useful to our society. Our staff could be strengthened and augmented by studying business management techniques to evaluate efficacy of our operations and personnel.

(2) Communications to our membership must be augmented by an increased role of our councilors to carry out their mission as put forth in our Constitution and Bylaws. This would help strengthen the interphase between our officers, staff, and the membership.

(3) The survey as proposed in the House of Delegates resolution relating to unionization and/or foundations must we weighed carefully by this body.

(4) A second resolution relating to election of officers by the entire membership should receive your careful consideration. This and other efforts to involve the entire membership will continue to be important to our organization. This involvement of the entire membership is an effort to be more democratic in the election of our state officers.

(5) To hear consumer complaints, a system of ombudsmen should be considered. These individuals could serve as an arm of our Grievance Committee. Nuisance suits, for malpractice, might be fewer if patients had an open communication system into the medical community.

(6) A renewed emphasis to enroll new members will be forthcoming. Emphasis on communication and education of all physicians to the affairs of organized medicine will continue to be carried out. Our Medical Society must identify doctors' needs and then react accordingly. During the forthcoming year, we hope to become more aware of this and gain input into our thinking, by conducting several sensitivity sessions throughout the state. Would not a WATS line, for direct communication to the State Medical Society, be a helpful innovation? Would not an ongoing program of self-analysis be useful?

(7) We must learn how to better utilize our computer strength to assist physicians in the areas of billing, history taking, and multiphasic screening and research. WPS offers this potential.

(8) We must utilize our Past President's strength in a positive way through ongoing productive "think tank" sessions.

(9) Physicians frequently feel on the outside of affairs and activities of our body. I will encourage our *Wisconsin Medical Journal* to continue to publish the detailed makeup of our organization so that each physician will be able to study where he might have input into our affairs.

(10) Appropriate to the recommendations of the Commission on Scientific Medicine, the Council's Committee on Scientific Medicine should coordinate representation from the Commission on Hospital Relations and Medical Education and the Commission on Scientific Medicine to study in detail and make recommendations relating to continuing medical education.

The educators of our two state medical schools and representatives of government should aid our policies relating to this matter. Together they could stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing medical education programs. The ultimate goal of this committee would be to set up a free-standing independent council to govern the entire area of continuing education including new educational methods, techniques, and systems, and to discover educational needs through self-testing and other motivational devices.

(11) It is appropriate that I mention and commend our Long-range Planning Committee for its hard work. This committee should continue to give input into your Society and help it by studying the standing committee structures and by clarifying their responsibilities.

(12) We must build on our present Checkpoint/Checkmate program. Such a positive effort has been invigorating to all participants. Legislative contact must be strengthened to maintain our lines of communication to our legislators. Their help is vital to our best interests.

(13) What is the responsibility of the State Medical Society to educate the citizens of this state to concepts of good health in such areas as home, industrial and highway safety; nutrition; problems of drug abuse, alcoholism and matters of sex education? Should our efforts be to change life styles to permit people to enjoy the good things of life in good health? The responsibilities of our Commission on Health Information should be reviewed in this area of involvement.

In conclusion, let me state that we must not be fearful. We must not over react. Our strength will continue to be through our productivity, being responsive to need, and our ability to negotiate well. We must make reasonable responses to the basic issues we face. In order to maintain our number one position in the eyes of our patients, we must continue to emphasize our most valuable assets—our head, our heart, and our hands. With this emphasis the term health-care crisis, which stems from the creation of political idealism, will melt away.

These are indeed exciting and demanding times. I accept the challenge! □

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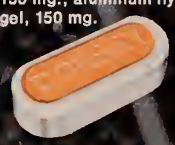

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This printing of the Constitution and Bylaws of the State Medical Society of Wisconsin includes a number of amendments which were adopted by the House of Delegates at its Annual Session March 25–27, 1973 in Milwaukee.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through March 1973.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

SEC. 4. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds an unlimited license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess

to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election. Such resident members shall have the right to vote and hold office.

SEC. 5. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 6. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

SEC. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 8. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 9. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

SEC. 10. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 11. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

SEC. 12. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 12, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

COMMENT: Reference Committee on Finances was authorized by the House of Delegates at May 1967 Annual Meeting.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its final meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district, and one delegate representing all of the scientific sections. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at the next annual session. No two candidates for president elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the

vacancy occurs in the representation from the scientific sections, such vacancy shall be filled by ballot of the several section chairmen.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition

of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Health Information.
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

COMMENT: In May 1967, the House of Delegates changed the name of the Commission on Public Relations and Communications to the Commission on Health Information.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of nine members, each of whom shall serve for a term of three years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. Unless otherwise expressly provided in these Bylaws, memberships for expired terms as well as the chairman of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates; provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two and three years, and thereafter for terms of three years.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which such person is a member.

Standing committees and commissions shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the commission.

SEC. 2. The Commission on Scientific Medicine shall consist of nine appointed members, the deans of the two medical schools in Wisconsin, and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve a term of three years, and initial terms shall be staggered so that the terms of one third of the appointed members shall expire each year.

The Commission on Scientific Medicine shall study, develop and present programs of postgraduate and continuing education for the membership through the State and component societies and in

such other ways as it may find feasible. It shall serve as the Society's coordinating body with similar education programs for physicians and allied health personnel in cooperation with the medical schools in Wisconsin and other governmental and voluntary organizations having a proper interest in this field. It shall assist the specialty societies in their postgraduate and continuing education endeavors. It shall work with the Society's peer review mechanism to influence self-assessment and self-improvement through scientific programs among the members of the Society.

The Commission shall also study the character and scope of the scientific proceedings of the Society and prepare the scientific program for the annual meeting.

SEC. 3. The Commission on Health Information shall study, make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may create an executive committee consisting of the seven representatives from the membership at large.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena.

COMMENT: In May 1967, the House of Delegates repealed Section 5 of Chapter VII and substituted the present wording.

SEC. 6. The Commission on Hospital Relations and Medical Education duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required. at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

ertisement

"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Are there significant differences in bioavailability and clinical predictability among drug products?

Opinion

Results of a questionnaire to 7,000 physicians:

44.6%
Agree there is a significant difference

24.9%
Believe there is no difference

30.5%
Had no opinion

Are there significant differences in bioavailability and clinical predictability among drug products

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University

I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictability More Important Than Pr

Although the questio price has been greatly aggerated, it is true t patients can on occas save money on gene drugs. But you are not ing to dare attempt to s money if it jeopardizes patient's health. Let's turn to the example t has become very promin in recent years, that of cardiac glycosides. T are probably the most to drugs we use with resp to the small difference tween a maximally effect dose and a toxic dose. W you are dealing with dr of this type, the first c cern must be clinical p dictability. At the risk variations in bioavailal ity, it would be sheer fo to try to save the pati what might amount maybe $10 or $20 a ye The physician cannot m age his patient unless h sure that the drug he prescribing has the sa positive effect each t the prescription is renew This is especially sign cant when the patient ta the product, not for mont but for the rest of his life

Maker of Medicine

C. J. Cavallito, Ph.D.
ecutive Vice President
Ayerst Laboratories

lthough equivalence of erent preparations of a *g substance* may be de-d by certain physical, mical or biological char-eristics, identity is not ays assured even though se characteristics may described in compendia h as the USP, NF or de-ed by other specific rce standards. More-r, even with equivalent g substances, similar rmaceutical *products* be produced by differ- manufacturers such t these products are hio-ically or therapeutically quivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases h drug substances de-ed from different sources l under different condi-ns, it should be possible stablish specifications in ficient detail to minimize potential for their non-uivalence. However, re is general agreement t product therapeutic uivalence would still not assured even if one could minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

COUNCIL MINUTES—State Medical Society of Wisconsin
MADISON, FEBRUARY 10, 1973

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:40 p.m. on Saturday, February 10, 1973, at the State Medical Society.

Voting members present: Doctors John Foley, Olsman, Nordby, Huth, Beilman, Edwards, Smejkal, Mauthe, Dettmann, Rohde, Heinen, Manz, Doyle, Egan, LaBissoniere, Pittelkow, Schmidt, Meyer, Past President Behnke, President Purtell, Speaker Nereim.

Others present: Doctors Derus, Hamlin, Weston, Bell, Galasinski, Hildebrand, Dessloch, Russell, Kief, Krohn, Goldstein, Headlee, Jordon Frank, Handy and Biek; Messrs. Thayer, Koenig, Maroney, Brower, Reynolds, Doran, Brodersen, Bontrager, LaBissoniere, Lindemann, Johnson, Graham, McIntyre, Murphy, Tinkham, Tiffany, Gill; Mmes. Anderson and Davenport; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Dettmann–Behnke, carried, minutes of the November 11, 1972, meeting were approved.

3. WPS Separate Incorporation

The Commission on Medical Care Plans, meeting on February 9, 1973, adopted by a majority vote the following resolution:

> RESOLVED, That the Council be asked to authorize the reorganization of WPS by the Commission on Medical Care Plans as a mutual insurance corporation, and the transfer to such corporation of the assets and business of WPS, including the assumption of all WPS liabilities.

The Executive Committee of the Council had discussed this action and after considering alternatives available presented the following amended resolution to the Council:

> RESOLVED, That the Executive Committee recommends to the Council the reorganization of WPS by the Commission on Medical Care Plans under Chapter 611 of the Statutes, preferably as a stock insurance corporation, or in the alternative as a mutual insurance corporation, and the transfer to such corporation of the assets and business of WPS, including the assumption of all WPS liabilities.

After Council discussion, the recommendation of the Executive Committee was adopted (motion of Doctors Nereim–Doyle) with an amendment proposed by Doctors Behnke–LaBissoniere, as a recommendation to the House of Delegates as follows:

> RESOLVED, That the Council recommends to the House of Delegates the reorganization of WPS by the Commission on Medical Care Plans under Chapter 611 of the Statutes, preferably as a stock insurance corporation, or in the alternative as a mutual insurance corporation, and the transfer to such corporation of the assets and business of WPS, including the assumption of all WPS liabilities; provided that if the Insurance Commissioner turns down incorporating under Chapter 611 as a stock company, the matter will then be brought back to the Council before there is approval of the mutual route.

4. Commission on Hospital Relations and Medical Education

The Commission had considered a revised statement proposed for adoption by the AMA House of Delegates entitled "Functions and Structure of a Medical School." State societies had been asked to review the statement, and the Commission recommended that the Wisconsin delegation to the AMA endorse its adoption.

Doctor Galasinski pointed out that further revisions of the statement were expected to be introduced for consideration by the AMA House of Delegates, and he suggested that the Council approve the statement in principle, stressing the concept that undergraduate medical students first receive basic training to become physicians, then let them consider which field they wish to go into.

On motion of Doctors Dettmann–Smejkal, carried, such position was adopted by the Council.

5. Commission on Public Policy Report on Legislation

Doctor Russell reported on the following subjects considered by the Commission on February 7:

(a) Professional Liability

Legislative proposals related to professional liability for possible introduction by the Society were referred to the Council Committee on Economic Medicine for its review and comment.

(b) Laboratory Licensing

The Commission referred back to the Section on Pathology a pending proposal with the request that it consider a quality assurance rather than a licensing approach.

(c) Chiropractic

The Commission approved certain of the legislative proposals recommended by the Ad Hoc Committee on Chiropractic which were outlined for the information of the Council.

A number of other legislative proposals were reviewed by the Commission in light of existing Society policy.

Jordon Frank, MD, asked that the Council reconsider the official position of the Society on employment of physicians legislation, pending action by the House of Delegates in March on a resolution introduced by the Rock County Medical Society requesting opposition of the repeal of existing Wisconsin law prohibiting the employment of physicians by hospitals.

It was pointed out that the Task Force bill on employment of physicians had not yet been seen. The stipulations adopted by the House of Delegates in 1971 were reviewed; also the proposal of the Executive Committee of the Council that deletion of reference to pathology, radiology and physical medicine be requested so that the bill would apply to any physician, with retention of the provision on approval by the medical staff of contractual relationships.

6. Committee on Economic Medicine

Doctor Schmidt reported recommendations on:

(a) Travel Accident Insurance

On motion of Doctors Schmidt–Beilman, carried, the Council approved upgrading of this coverage as recommended by the committee. Part of the increased benefits applicable to covered officers, committee members and certain staff would be allocated equally between the Society and the designated beneficiary or estate of the insured. Benefits for those employees covered only for accidental death while on Society business would be payable entirely to the beneficiary or estate. The committee will continue its consideration of including additional Society committee members in the coverage.

(b) Key Man Insurance

The committee has requested management to identify the positions recommended for this coverage so that a fiscal note can be prepared for report back through the Finance Committee.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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(c) Automobile Leasing

The committee reported that it had reviewed the proposal submitted by Lease Associates, Inc., found it to be satisfactory, and suggested that the program be offered to those members of the Society who might be interested. It is expected that Lease Associates will bear all costs of promotion and administration.

On motion of Doctors Schmidt–Behnke, carried, the Council acted favorably on providing this service to the membership, with permission to Lease Associates to solicit the business.

Doctor Heinen gave the balance of the report since Doctor Schmidt had left for a meeting of the Executive Committee:

(d) Provident Disability Insurance Program

On motion of Doctors Heinen–Edwards, carried, the Council approved the recommendation that an intensive effort be undertaken to increase participation in the program through an open enrollment campaign directed to members under age 40 without underwriting, and to non-participating members over 40 subject to underwriting. Depending upon the success of this effort, Provident will consider increasing maximum benefits of the program.

The committee also reported it is considering a special disability insurance offering to resident members of the Society and will report later to the Council.

(e) Professional Liability

Several legislative proposals had been referred to the committee by the Commission on Public Policy for review and comment. The committee recommended the Society take no position on legislation to prohibit attorneys from using contingent or percentage fees in professional liability suits.

On motion of Doctors Heinen–Beilman, carried, the Council approved the committee's recommendation that the Society support a two year statute of limitations on actions involving special confidence.

As for other proposals referred by the Commission, the committee recommended continuation of present policy which places the Society in support of any activity which would alleviate the professional liability problems in Wisconsin.

7. Finance Committee Report

(a) Employees Pension Plan

Doctor Dettmann reported that 36 employees became participants in 1973, bringing the total to 242.

As pension plan trustees, the committee recommended that investment of the fund be committed to the First Wisconsin National Bank of Madison.

(b) General Fund Financial Report

Doctor Dettmann reported on the status of the special assessment fund for education on chiropractic; on the favorable balance in reserves at the end of 1972; that negotiations will probably be consummated with Gibbs–Inman of Louisville for printing the *Wisconsin Medical Journal* at a considerable monthly savings; and on interim arrangements for representation in the Legislature since Mr. McIntyre had been transferred to executive direction of WHCRI.

On motion of Doctor Schmidt, seconded and carried, the report of the Finance Committee was accepted.

8. Committee on Peer Review

Mr. Brower discussed the report of this Council committee which was accepted for forwarding to the House of Delegates.

9. Medical Advisory Services to Workmen's Compensation

The Council had received a report from Doctor Olsman for the Committee on Occupational Health concerning proposals of George A. Hellmuth, MD, to develop through legislation a formal medical advisory council to the Workmen's Compensation Division. After lengthy study the committee recommended that the Society's effort be directed to:

(a) Inform and educate the medical profession in the problems involving occupational health;

(b) Provide medical consultation and advice to the Workmen's Compensation Division at the highest level; and

(c) Urge that more effective medical and vocational rehabilitation referral programs be made available to the disabled worker under the provisions of the current Wisconsin Statutes.

On motion of Doctors Olsman–Schmidt, carried, these recommendations were accepted by the Council for inclusion in the committee's report to the House of Delegates.

10. Annual Meeting

Councilors and officers present received their handbooks containing all resolutions and such reports as were ready for distribution. Plans were announced for district caucuses.

11. Wisconsin Health Care Review, Inc.

Mr. McIntyre gave an informational report on recent actions of the board of directors which had been expanded to include four public members. He distributed organizational materials which were under consideration and as to which he requested reactions from the local districts.

There were also comments from Doctor Hildebrand as to the importance of PSRO legislation, though implementing rules and regulations have not yet been written.

12. Early and Periodic Screening, Diagnosis and Treatment Program under Title XIX (Medicaid) in Wisconsin

The Council received detailed information on this program required by SSA amendments for all Medicaid-eligible persons under age 21. The Society is represented by one physician on an advisory committee, and at the request of the Executive Committee, several others were asked to join in a special Society effort to suggest an alternate approach to the conduct of this program at the local level since it was felt that the plan contemplated by the Department of Health and Social Services could be much more effective with little additional expenditure of funds. This was acceptable to the Council.

13. Executive Session

The Council held an executive session in which Doctor Purtell's nomination for the recipient of the Presidential Citation was approved; the status of committee of eight discussions was reported; salary increases for two WPS executives were approved; and the Council approved the original recommendation of the Executive Committee for the resolution of disputes with regard to customary, usual and reasonable fees, as communicated to the Medical Society of Milwaukee County on August 16, 1972, for application to the settlement of all such disputes; regardless of the type of insurance carrier involved, and that all county medical societies be so advised.

14. Adjournment

The meeting adjourned about 5:30 p.m.

EARL R. THAYER
Secretary

Approved March 24, 1973
EUGENE J. NORDBY, MD
Chairman

NEWS HIGHLIGHTS

Wisconsin Society of Pathologists Elects

At the recent annual meeting of the Wisconsin Society of Pathologists the following officers were elected for 1972–73: president—C. P. Erwin, MD;* president elect—M. D. Blackburn, Jr., MD;* vice-president—D. M. Connors, MD; secretary and councilor to ASCP—R. C. Brown, MD;* treasurer and alternate councilor to ASCP—D. J. Stevenson, MD;* board of censors—D. J. La Fond, MD* (chairman), E. F. Sabado, MD* and R. A. McCormick, MD;* and delegate to the State Medical Society of Wisconsin—H. J. Dick, MD.*

Wausau Medical Center Has Executive Director

The Wausau Medical Center recently announced the appointment of an executive director who will be in charge of general management and long-range planning for the Center. He is Frank Montague, who has been a health service consultant in New York City with A. T. Kearney and Co. In 1969 he was on assignment in Wausau with the planning council that recommended merger of the city's two hospitals, which since has been accomplished. The Medical Center started in 1962 with 12 physicians and now has 42 representing 16 specialties.

Masonic Diagnostic and Treatment Center Planned

In March it was announced that Wisconsin Masons will be expected to contribute $1.5 million to establish a four-story Masonic Diagnostic and Treatment Center to be operated by Deaconess Hospital in Milwaukee. The facility will adjoin the hospital and be occupied before the end of this year, according to information from Kenneth S. Jamron, executive director of the hospital. A nonprofit coordinating corporation called the Wisconsin Masonic Medical Institute has been formed. Nine directors represent the fraternity and the other nine represent the hospital. Said Sheldon Ausman, president of the Masonic Medical Foundation of Wisconsin: "The association we have established between the fraternity and the hospital for the operation of this major health care facility is unique in the United States. Nowhere but in Wisconsin have the Masons committed themselves so completely in a coordinated effort that will ultimately benefit a great number of people."

Spring Perinatal Day Set for Madison

The Wisconsin Perinatal Center, Southcentral Region at Madison will hold its annual Spring Perinatal Day April 18. The one-day seminar for physicians and nurses will be held in the Assembly Hall at St. Marys Hospital Medical Center in Madison. Theme for the meeting will be "A New Look at Old Problems."

Topics to be presented will be Prenatal Nutrition and Fetal Effects, Staphylococcal Infection of the Newborn and Control, Management of Ruptured Membranes—Maternal and Newborn Aspects, Hyperbilirubinemia of the Newborn—Use of Phototherapy.

There also will be workshops dealing with problems of management of the difficult breech delivery, use of the oxytocin stress test, use of intrauterine steroids to prevent hyaline membrane disease, preparation of the sick infant for transport, new aspects of routine newborn care, parental response to the sick infant, intrapartum monitoring and evaluation of the newborn with apnea and bradycardia.

PHYSICIAN BRIEFS

William W. Baird, MD*

. . . Wauwatosa, recently took office as chief-of-staff of West Allis Memorial Hospital for a two-year term succeeding Thomas F. Jennings, MD,* Elm Grove. Henry F. Twelmeyer, MD,* Wauwatosa, was elected as chief-of-staff-elect to serve a two-year term, and continuing in office for another year is Marvin D. Miller, MD,* West Allis, as secretary–treasurer.

George E. Cassidy, MD*

. . . Manitowoc, recently became associated with MDs Michael A. Jacobi* and Gilbert H. Stannard* in the practice of radiology. Doctor Cassidy attended Marquette University School of Medicine and served his internship at Columbia Hospital in Milwaukee. His residency was obtained at the Medical College of Wisconsin (formerly Marquette) and he is certified by the American Board of Radiology.

Constantine Panagis, MD

. . . Milwaukee, associate professor at the Medical College of Wisconsin and director of long-term care services at the County Institutions and medical director of the Milwaukee County Rehabilitation Hospital, recently assumed the position as Milwaukee Health Commissioner. He succeeds E. R. Krumbiegel, MD* who retired. Doctor Panagis is on the senior attending staff at County General Hospital and on the attending staffs of St. Joseph's and St. Anthony's hospitals.

Allen O. Tuftee, MD*

. . . Beloit, recently was named president of the Beloit Memorial Hospital medical staff. A Beloit resident for 14 years, Doctor Tuftee succeeds William A. Pruett, MD.* Other MDs elected are: Jordan Frank* and Edward Onderak, president-elect and secretary–treasurer, respectively.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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PHYSICIAN BRIEFS . . .

H. Kent Tenney, MD*

. . . Madison, emeritus clinical professor of pediatrics of the University of Wisconsin Medical School, recently was featured in the *Green Sheet Section* of the MADISON CAPITAL TIMES. Doctor Tenney, who for nearly 40 years, divided his time between teaching medicine at the University of Wisconsin and practicing pediatrics at his clinic, has by no means "retired." Since 1960 he has offered accumulated knowledge through his weekly radio program, "The March of Medicine" sponsored by the State Medical Society of Wisconsin. Doctor Tenney has personally researched and outlined each of the 673 programs stretched over the past 13 years.

Jacques Hussussian, MD*

. . . Milwaukee, assumed the office of president and chief of staff of Trinity Memorial Hospital at its annual meeting in January. Doctor Hussussian joined the medical staff at Trinity in 1967. Other MDs reelected to office were: Wayne L. McFadden,* Milwaukee, vice-president, and John W. Cornell,* Cudahy, secretary–treasurer.

J. M. B. Bloodworth, MD*

. . . Madison, professor of pathology, recently served on the faculty of the International Academy of Pathology's postgraduate education program during the group's annual meeting. He taught a course on "Pathology of Diabetes Mellitus."

Markham Fischer, MD

. . . Ashland, recently became associated with the staff of the Ashland Memorial Medical Center. He graduated from Washington University Medical School in 1966 and served his internship at Ramsey County Hospital, St. Paul. He also served in the United States Navy for two years. Doctor Fischer completed his residency in radiology at the University of Minnesota and Veterans Administration Hospitals in Minneapolis.

NEWS HIGHLIGHTS . . .

Milwaukee Academy of Family Physicians Elects

Donald B. Lindorfer, MD* has been elected president-elect of the Milwaukee Academy of Family Physicians. He succeeds Nicholas DeLeo, MD* who was installed as president of the 250-member organization. Samuel Sweet, MD* and Gojko D. Stula, MD* were reelected treasurer and secretary, respectively.

Milwaukee Academy of Surgery Elects

Shimpei Sakaguchi, MD* and Donald P. Davis, MD* were recently elected president and president-elect, respectively, of the Milwaukee Academy of Surgery. Also named officers at the annual meeting were Victor M. Bernhard, MD,* secretary–treasurer, and Edward A. Bachhuber, MD,* recorder.

Monroe Clinic Doctors Honor Their Administrator

Harold E. Scherer, administrator of the Monroe Clinic since its beginning 36 years ago, in February was honored by doctors and longtime associates during a luncheon at the Monroe Country Club, marking his retirement. "He has given a unique stamp of character to every single thing we have done over the years," Leslie G. Kindschi, MD* said during a brief program.

Chippewa County Society Hears Mayo Clinician

On February 6 fifteen members of the Chippewa County Medical Society met in Chippewa Falls. Dr. James McPherson of the Mayo Clinic, Rochester, Minn., discussed biliary diseases and jaundice. During the business session, Title 19 problems were discussed as well as the shortage of physicians. Members also heard a discussion by delegates to the State Medical Society's Annual Meeting of the House of Delegates.

Edgewood College Offers Registered Nurses Opportunity to Obtain Bachelor's Degree

Edgewood College in Madison has announced a program that will allow registered nurses to obtain a bachelor's degree. The College will grant a 30-credit allowance to RNs for their previous professional studies.

This offering, believed to be unprecedented in Wisconsin, will apply only to registered nurses who already have graduated from a National League of Nursing approved diploma program, or who possess an A.A. in nursing from an accredited college. The nurse-students must be serious about earning a degree, the college stipulates, choosing an approved major and fulfilling the usual other requirements for graduation.

Scheduled to go into effect next fall, the program was proposed and researched by Edgewood's educational development committee, a group devoted to organizing new curricula for the college. It is intended to assist nurses who wish to receive recognition for previous professional studies, yet desire to earn a bachelor's degree in addition to a professional degree in nursing, which Edgewood College does not offer.

Registered nurses who wish to discuss this program further are urged to contact the Office of Adult Education at Edgewood College.

PHYSICIAN BRIEFS . . .

David Trudeau, MD

. . . Washburn, recently became associated with the medical staff of Bayfield County Memorial Hospital. Doctor Trudeau is a graduate of the University of Minnesota Medical School and completed his internship at the University of Cincinnati. He served in the United States Air Force as a physician for two years, and also conducted a family practice in Austin, Minn.

John H. Scofield, MD

. . . Oconomowoc, recently became associated with the Wilkinson Clinic. A graduate of the University of Nebraska College of Medicine, he completed his internship and surgery residency at Southern Baptist Hospital in New Orleans. He served in the United States Navy for two years and had surgery training at the Welborn Hospital Clinic at Evansville, Ind.

Herman Schulz, MD*

. . . Edgar physician since 1930, recently was presented with the first annual La Count Award by the Marathon County Medical Society. Physicians from throughout north central Wisconsin attended the banquet at which the award was presented. The featured speaker was C. A. Hoffman, MD, Fayetteville, N.C., president of the American Medical Association. The award which is given for "distinguished health care service" also was presented to Walter Zeit, PhD, Medford, a medical educator at Marquette University for 51 years until his retirement in 1972.

John J. Frederick, MD*

. . . Cudahy, chief of the department of surgery for two terms of Trinity Memorial Hospital, recently was elected president of the advisory board of the hospital. He joined the medical staff at Trinity in 1958.

Lawrence L. Foster, MD*

. . . Elm Grove, recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons at its annual meeting.

Thomas Aaberg, MD*

. . . Elm Grove, and a member of the Medical College of Wisconsin faculty, appeared before a meeting of the Wisconsin Council of the Blind and secured a donation of $12,000 from the Antoinette Hoeger Dohmen Memorial Fund. The money will be used to purchase additional equipment to be used in ophthalmic surgery.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1973

1 Permanent Commission on the Museum of Medical Progress and Executive Committee, CES Foundation
2 Wisconsin Public Health Association
4 Third Councilor District Caucus
5 Dane County Medical Society Insurance Advisory Committee
6 Madison Urological Society
6 Madison Anesthesiology Society
6 Dane County Medical Society Board of Trustees, Delegates and Alternates
7 National Board Exams: Interns and Residents of University Hospitals
9 Medical Advisory Committee, Wisconsin Emergency Medical Services Program
13 Dane County Medical Society
15 Executive Committee and Board of Directors, Wisconsin Association of Professions
22 Madison Academy of Internal Medicine
23 *Executive Committee of SMS Council (Milwaukee)*
24 *SMS Council (Milwaukee)*
25 *SMS Annual Meeting (Milwaukee)*
25 *SMS House of Delegates (Milwaukee)*
26 *SMS Annual Meeting (Milwaukee)*
26 *SMS House of Delegates (Milwaukee)*
27 *SMS Annual Meeting (Milwaukee)*
27 *SMS House of Delegates (Milwaukee)*

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Robert G. Wochos, MD*

. . . Green Bay, is serving his second tour of volunteer service aboard the S. S. HOPE. He was to serve until mid-April aboard the floating medical center in northeast Brazil where the ship docked in Maceio on its 11th medical teaching–treatment mission. His first tour aboard the hospital ship was in 1967 during the HOPE's mission to Colombia.

Dean A. Emanuel, MD*

. . . Marshfield, in March was the recipient of the American Dairy Association of Wisconsin's annual Cowbell Award. While president of the Heart Association in 1971, Doctor Emanuel was chairman of a task force that studied and made recommendations on the diet in relation to heart disease. He "gained the respect and appreciation of Wisconsin's dairy industry by his willingness to cooperate with the dairy industry and nutritionists in reaching accord on dietary recommendations to the general public," the dairy group noted.

Richard D. Stewart, MD*
Anthony A. Herrmann, MD*

. . . are playing a significant role in the development of a model industrial medical facility at the Waxdale production, shipping, and warehousing complex of S. C. Johnson & Co., Inc., near Racine. The model facility has a two-fold purpose—that of providing comprehensive medical care to the 2,500 Johnson employes while simultaneously providing a training program for residents in occupational medicine. Doctor Stewart, chairman of the Department of Environmental Medicine at the Medical College of Wisconsin in Milwaukee, was appointed corporate medical adviser to Johnson about two years ago. He retains his college affiliation. Doctor Herrmann is director of medical services for Johnson. A former medical director for Delco Electronics in Milwaukee, Doctor Herrmann continues as an assistant clinical professor at the Medical College. Some of the inspiration for layout of the model facility came from the Mayo Clinic, some from Doctor Stewart's experience at Dow Chemical Co. in Midland, Mich., and some from Doctor Herrmann's at General Motors.

Paul G. Gottschalk, MD*
Cesar N. Reyes, Jr., MD*

. . . Marshfield, in March were elected for one-year terms to the Board of Directors of the Marshfield Clinic. The addition of these two doctors increases the Board to nine members which, according to Clinic president, David J. Ottensmeyer, MD,* will give the Clinic greater expertise to assure that the new directions undertaken will be in the best interests of the Greater Marshfield Community and others served by the Clinic. Other members of the Executive Committee are: MDs Jerry M. Hardacre,* Robert H. Greenlaw,* Ben R. Lawton,* Gerald E. Porter,* and Richard H. Ulmer.*

Eric P. Kindwall, MD*

. . . chairman of the Department of Hyperbaric Medicine at St. Luke's Hospital in Milwaukee, spoke to the 53 members of the Winnebago County Medical Society which met February 1 in Menasha. His subject was, "Clinical Applications of Hyperbaric Medicine."

Owen Miller, MD*

. . . Waukesha, in February was named chairman of the State Medical Society's Committee on Peer Review by the Executive Committee of the Council. It also named Rocco Latorraca, MD* of Wauwatosa as the vice-chairman. The appointments followed a request of Paul B. Mason, MD* of Sheboygan that he be relieved of the chairmanship of the Peer Review committee so that he could devote more time to his position as president of the Wisconsin Health Care Review, Inc. (WHCRI).

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PHYSICIAN BRIEFS . . .

Joseph McGrath, MD

. . . Pepin, a graduate of the University of Minnesota Medical School has affiliated with the Wabasha Clinic and recently opened offices in Pepin.

M. John Murphy, MD

. . . La Crosse, recently joined the medical staff of the Gundersen Clinic and Lutheran Hospital. Doctor Murphy graduated from Creighton University Medical School, Omaha, Neb., in 1967 and served his internship at Creighton Affiliated Hospitals in Omaha. He completed his neurology residency at the University of Wisconsin–Madison and prior to coming to the Gundersen Clinic, was on the staff of the Diagnostic Clinic, Houston, Tex.

James F. McIntosh, MD*

. . . Madison, recently was elected to his third term as chief of the medical staff of Madison General Hospital. Other MDs elected were: George L. Lucas,* vice-chief; William P. Crowley,* secretary–treasurer; and B. E. Stein,* representative to the Dane County Medical Society.

Marvin Vos, MD

. . . Wisconsin Rapids, recently joined the staff of the Riverwood Clinic in Wisconsin Rapids. A native of Iowa, he graduated from the University of Iowa Medical School and served his internship at Swedish Hospital, Seattle, Wash. Prior to coming to Wisconsin Rapids, he completed a two-year residency at Ventura County General Hospital in California, and has been certified a diplomate by the American Board of Family Practice.

Edwin B. Bercovici, MD*

. . . has recently opened an office for the practice of ophthalmology in Milwaukee. He is a clinical instructor at the University of Illinois College of Medicine. Further details appear in the Section on Ophthalmology page elsewhere in this issue. □

NEWS HIGHLIGHTS . . .

UW Hospitals Has New Trauma and Life Support Center

A center specially designed to care for patients who have incurred major trauma, burns or other medical catastrophies has opened at University of Wisconsin Hospitals, Madison.

The new unit, the Center for Trauma and Life Support, is directed by Allen Katz, MD from the anesthesiology department; Marvin Birnbaum, MD, medicine; and Joseph Moylan, MD,* surgery. This association with the three departments in a critical care unit is unique in the United States, the directors pointed out.

The unit is equipped with sophisticated cardiopulmonary machines with on-line computers that record and program all data on a patient's condition. Patients with infection are placed in isolation rooms that have this same critical care support. A physician is in attendance on the unit 24 hours a day, and the nurse–patient ratio is one-to-one.

The directors hope that with the establishment of a unit where the main emphasis is on care of patients with multiple system failures, the accidental death rate in Wisconsin can be reduced.

Pediatric Intensive Care Unit Opened in Madison

Madison General Hospital has announced the opening of a six-bed Pediatric Intensive Care Unit. The unit is staffed by registered nurses specially trained in pediatric intensive care. Physician consultants in all specialties and subspecialties, as well as pediatric residents and interns in house, are on 24-hour call.

The new unit is equipped with electronic monitoring, including telemetry, for EKG, arteriovenous pressure, temperature, and respiration. Each bed is also monitored by television. The $30,000 equipment was purchased by the Hospital Auxiliary.

The unit, a center for the care of critically ill children in south central Wisconsin, retains the service of nurse clinicians in pediatrics, cardiopulmonary care, orthopedics, and neurology.

Charles Jahn, MD* is chief of pediatrics at Madison General Hospital in Madison.

Health-Care Groups Sponsor "Huffer–Puffer" Club

The "Huffer-Puffer" Club—a new club formed for anyone afflicted with emphysema and other chronic respiratory diseases, and their spouses—had its first organizational meeting March 15 at the Oak Forest Sanatorium in La Crosse. This is the first such club formed in Wisconsin. Similar clubs have been formed in other states. A second Wisconsin club is expected to start this spring in the Milwaukee area.

The club is sponsored by the Adolf Gundersen Medical Foundation, Gundersen Clinic, Ltd., La Crosse Lutheran Hospital, St. Francis Hospital, the Wisconsin Respiratory Care Society, and the Southwest Branch of the Wisconsin Tuberculosis and Respiratory Disease Society.

Tri-County Medical Society Meets in Ashland

Twenty-four members of the Ashland–Bayfield–Iron County Medical Society met February 28 in Ashland. State Senator Daniel Theno addressed the group on legislative matters. Also speaking before the group was Edward Kastner of the State Medical Society field service staff. He discussed peer review activities.

Milwaukee Gastroenterological Society Installs Officers

The Milwaukee Gastroenterological Society held its annual dinner in March at the University Club of Milwaukee at which time the following officers were installed: John E. Dooley, MD,* Milwaukee, president; and Joseph E. Geenen, MD,* Racine, secretary–treasurer. □

SECTION OPHTHALMOLOGY

APRIL 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Doctor Bolger (left) receives engraved silver bowl from Section chairman Doctor Parks in recognition of his tireless efforts on behalf of the Section on Ophthalmology.

DOCTOR BOLGER RECEIVES RECOGNITION

Dr. James V. Bolger, Jr. of Waukesha was presented an engraved silver bowl in recognition of his contributions to the Section on Ophthalmology of the State Medical Society of Wisconsin during the Society's Annual Meeting, March 25–27, in Milwaukee. Making the presentation was Section Chairman Dr. W. Carson Parks of Milwaukee.

Doctor Bolger, more than any one person, has made the Section on Ophthalmology the strongest, most vigorous, most active section of all the scientific sections of the State Medical Society. Only he knows how many hours of his time have been given to helping his fellow physicians and the public causes. The people of Wisconsin are fortunate to have such a devoted physician as Doctor Bolger and physicians are fortunate also in having such a fine colleague as Jim Bolger.

NEW OPHTHALMOLOGIST IN MILWAUKEE

Dr. Edwin Bercovici has opened an office to practice ophthalmology in Milwaukee. He received his MD degree from the University of Nebraska College of Medicine in 1963. He interned at the University of Pennsylvania and was a flight medical officer in the United States Air Force following his internship. He was an ophthalmology resident at the University of Illinois College of Medicine and the Illinois Eye and Ear Infirmary from 1967 to 1970. Following his residency he was a clinical instructor in ophthalmology at the University of Illinois, and he was the Chief of the Ophthalmology Section at the Westside Veterans Administration Hospital in Chicago from July 1, 1970 to September 30, 1971. In October 1971 he began a Heed Fellowship in ophthalmic plastic surgery under the preceptorship of Dr. Byron Smith at the Manhattan Eye, Ear, and Throat Hospital. He also studied ophthalmic ultrasonography under Dr. Nathaniel Bronson. He is a diplomate of the American Board of Ophthalmology and subspecializes in ophthalmic plastic surgery and ophthalmic ultrasonography. He has an ultrasonography B-scan in his office. He is a clinical assistant professor of ophthalmology at the University of Illinois College of Medicine, and a clinical instructor of ophthalmology at the Medical College of Wisconsin, Milwaukee.

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

Dr. John Ottum, Green Bay, president of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, has announced that the Fall Meeting of the Society will be held at the Downtowner Motel in Green Bay, October 6 and 7.

BLIND COUNCIL SUPPORTS EYE OPERATIONS

The Wisconsin Council for the Blind in February announced a gift of $12,000 to the Medical College of Wisconsin, Milwaukee, for the purchase of supplementary equipment for the practice of vitrectomy.

This new surgical procedure holds out hope for patients blinded for years from hemorrhage or opacities that block transmittal of light through the vitreous chamber of the inner eye. Dr. Thomas Aaberg, associate professor of ophthalmology at the Medical College, has recently begun the procedure at Milwaukee County General Hospital.

Since the operation is performed under a very high powered microscope, part of the gift money has been used to purchase a specially designed microscope. Doctor Aaberg had been using a standard microscope for operations.

The Wisconsin Council for the Blind is the only voluntary organization in Wisconsin exclusively devoted to the welfare of the State's blind citizens. Its members are all themselves blind and serve in an honorary capacity.

The Council derives its funds from numerous individual contributions and from the proceeds of a trust fund built up by many bequests received throughout the years. □

Help Needed to Rebuild Nicaraguan School of Nursing Library

Wisconsin physicians may wish to help support a special project launched by the faculty of the University of Wisconsin–Madison, School of Nursing to rebuild the library of the National School of Nursing at Managua, Nicaragua. The School was completely destroyed in the disastrous earthquake which struck the city on December 23 last year.

Rebuilding the library is considered by the School's faculty as a need of utmost importance and urgency. As a sister state in the Partners for the Americas, Wisconsin residents have contributed to the rebuilding of Managua, but the nursing library project is seen as a unique contribution by nurses for nursing.

The National School of Nursing functions under the auspices of the Ministry of Public Health with an academic three-year program. An average of 30 to 40 students are graduated each year, constituting over half of the total nurses who are graduated annually in Nicaragua.

Contributions may be sent to Norma Benavides, Partners of the Americas, 1856 Van Hise Hall, 1220 Linden Drive, Madison, Wisconsin 53706. Checks should be made out to the Partners for the Americas, and labeled "Nursing Library Fund." Contributions are tax-deductible, and receipts will be sent to contributors when requested.

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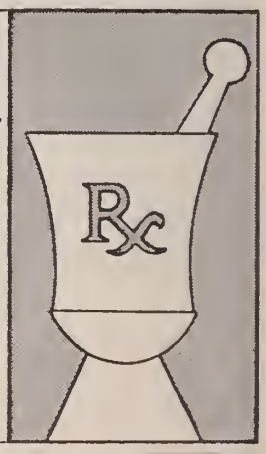

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OBITUARIES

Marcellus C. Haines, MD, 70, Oshkosh, died Dec. 30, 1972 in Oshkosh.

Born on Apr. 29, 1902 in Arcadia, Wis., Doctor Haines graduated from Marquette University School of Medicine in 1928 and served his internship at Mercy Medical Center in Oshkosh. He served with the United States Air Corps during World War II in the North African Theater of War as a flight surgeon and commanding officer at Casablanca. Doctor Haines entered general practice in Oshkosh in 1928 and was a former president and secretary of the Winnebago County Medical Society. In 1961 he was organizing chairman of the Winnebago Chapter of the Wisconsin Academy of Family Physicians.

He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Viola; and two daughters, Virginia of Oshkosh and Mrs. Curt (Carla) J. Baier, Appleton.

Konstantin Geocaris, MD, 46, Madison, died Jan. 18, 1973 in Madison.

Born on Sept. 8, 1926 in Chicago, Ill., Doctor Geocaris graduated from Northwestern University Medical School and served his internship at the United States Naval Hospital in Oakland, Calif. His residency was taken at the Menninger Clinic, Topeka, Kan. He served in the United States Navy during World War II and the Korean War.

Doctor Geocaris became associated with the teaching staff of the University of Oklahoma Medical School and later became an assistant professor of psychiatry at the University of Minnesota Medical School. In 1963 he joined the Department of Psychiatry at the University of Wisconsin Medical School and was an associate clinical professor until his death. He was a member of the Wisconsin Psychiatric Association.

He also was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Barbara; a son, Dan, and a daughter, Anne.

Raymond B. Dryer, MD, 72, Poynette, died Jan. 28, 1973 in Poynette.

Born on Nov. 1, 1900 in La Grange, Ind., Doctor Dryer graduated from the University of Michigan Medical School in 1925 and served his internship at Providence Hospital, Detroit, Mich. Doctor Dryer practiced general medicine in Poynette for ten years until 1942 when he entered the United States Navy and served in the South Pacific area during World War II. After service he completed his residency in neurology and psychiatry at the University of Wisconsin, passing his National Board examinations in 1948.

He then continued his medical career as a psychiatrist, working as a consultant to Waupun State Prison and with the Veterans Administration as well as engaging in private practice, until his retirement from medicine in 1963.

During his retirement years he devoted much time to nature study, conservation, and travel.

He was a member of the Wisconsin and American Psychiatric Associations, a member of the Columbia–Marquette–Adams County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Miriam; and a son, William B., Boulder, Colo.

James Alban Murphy, MD, 72, Milwaukee, died Jan. 29, 1973 in Milwaukee.

Born on Mar. 16, 1900 in Escanaba, Mich., Doctor Murphy graduated from Marquette University School of Medicine, Milwaukee, in 1925 and served his internship at Madison General Hospital, Madison. His residency was taken at St. Ann's Maternity Hospital, Cleveland, Ohio.

Surviving are his widow, Mary and four children.

Charles Joseph Arendt, MD, 49, Wisconsin Rapids, died Feb. 1, 1973 in Wisconsin Rapids.

Born on Aug. 16, 1923 in Wisconsin Rapids, Doctor Arendt graduated from the University of Wisconsin Medical School and served his internship at Mercy Hospital in Janesville. His residency was taken at Highland Park General Hospital, Highland Park, Mich. Doctor Arendt served in the United States Army during World War II. He was a member and past president of the Riverview Hospital medical staff and past president of the Wood County Medical Society.

He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow; and five sons, John, Thomas, Matthew, Michael and Joseph, all at home.

Harve Roy Sharpe, MD, 86, prominent Fond du Lac physician, died Feb. 3, 1973, in Fond du Lac.

Born on Oct. 24, 1886 in Highmore, S.D., Doctor Sharpe graduated from the University of Illinois Medical School in 1913, served his internship at Anchor Hospital, St. Paul, Minn., and was later chief surgeon of Calumet and Hecla Copper Mines, Calumet, Mich.

Doctor Sharpe began his practice in Fond du Lac in 1920 and retired in 1962. He was a fellow of the American College of Surgeons and also served as president and secretary of the Fond du Lac County Medical Society.

Surviving are his widow, a daughter, Mrs. Richard Mueller, Brookfield; and two sons, Harvey R. Jr. MD, Fond du Lac, and James R. of Millbrae, Calif.

David Linsey Boyd, MD, 33, his wife, Cindy, and their children, Stewart and Laurie, died Feb. 5, 1973 in Anchorage, Alaska, in a plane crash.

Doctor Boyd was born on Mar. 24, 1939 in Corry, Pa., and graduated from the University of Wisconsin Medical School, Madison, in 1956. His internship was served at King County Hospital, Seattle, Wash., and his residency was at University Hospitals, Madison. The family had been living in Anchorage.

Frederick H. Wolf, MD, 64, head of the University of Wisconsin–La Crosse Health Center since 1970, died Feb. 7, 1973 in La Crosse.

Born on Sept. 21, 1908 in La Crosse, Doctor Wolf graduated from the University of Wisconsin and Northwestern University Medical School, serving his internship at the Harvey (Ill.) and Cook County hospitals in Chicago. He did postgraduate work at the Polyclinic Hospital in New York City. Doctor Wolf returned to La Crosse in 1937 where he joined his father, Dr. Herman E. Wolf, in practice, and in 1966 he became affiliated with the University of Wisconsin–La Crosse Health Center.

Doctor Wolf served in the United States Army Medical Corps in the South Pacific during World War II and also was on the hospital staff of La Crosse and St. Francis hospitals. He was president of La Crosse County Medical Society twice and served on the Commission on Medical Care Plans of the State Medical Society of Wisconsin for sixteen years. He was a member of the American Academy of Family Physicians and American Medical Association.

Doctor Wolf was state president-elect of the Wisconsin Colleges Health Association, a board member of the American Red Cross, a Family Welfare Board member, and was on the state board of PACE (Professional Association for Civic Education), now called WISPAC.

Surviving are his widow, Dorothy; two daughters, Mrs. Donald (Penelope) Oines, Germantown, and Miss Robyn Wolf, La Crosse; and a son, Frederick S., of Onalaska.

Dr. Fred Wolf

La Crosse lost a good citizen and a good doctor this week with the death of Frederick H. Wolf at age 64.

The family name is a familiar one in these parts. Dr. Wolf was a third-generation descendant of a family that settled on a farm in Smith's Coulee in the 1850s.

His father, Dr. Herman Wolf, began his practice here in a day when La Crosse, like most communities, had many "family doctors." When Dr. Fred Wolf left private practice six years ago to join the student health center of the University of Wisconsin–La Crosse, he was one of the last of the general practitioners.

Like his mother, who for many years was a mainstay in the local Red Cross chapter and other civic enterprises, Dr. Wolf was active in professional and community offices.

His calm manner and his interest in people of all ages—he was a good listener—made him popular among UW–L students.

He will be missed, as a doctor and a friend. —EDITORIAL, reprinted with permission from *La Crosse Tribune,* Feb. 8, 1973.

James M. Sullivan, MD, 65, Milwaukee, former president of the Medical Society of Milwaukee County, died Feb. 11, 1973, in Milwaukee.

Born Apr. 25, 1907 in Milwaukee, Doctor Sullivan graduated from Marquette University School of Medicine, Milwaukee, in 1931 and served his internship at Milwaukee County General Hospital. His residency was taken at University Hospitals in Madison and he received a master's degree from the University of Pennsylvania Postgraduate School of Medicine in 1938.

Doctor Sullivan was clinical professor in the Department of Surgery at Marquette University and he served on the medical staffs of Columbia, St. Mary's, Milwaukee Children's, County General, St. Luke's, and the Veterans Administration hospitals.

During World War II, he was a lieutenant colonel in the United States Army and won the Legion of Merit medal. He was a former president of the Wisconsin Surgical Society and the Milwaukee Surgical Society and a member of the Milwaukee Academy of Medicine, Central Surgical Society, and a fellow in the American College of Surgeons.

Doctor Sullivan was Editorial Director of the *Wisconsin Medical Journal* from 1951–1959 and served on the Committee on Public Policy of the State Medical Society of Wisconsin from 1950–1962. He was an alternate delegate to the American Medical Association from 1958–1962 and also served on the State Medical Society Council from 1967–1971 when he resigned for health reasons. He was vice-chairman of the Council from 1968–1971.

Surviving are his widow, Ann; a daughter, Mrs. John (Mary Ann) Cashion, Wilmette, Ill.; and three sons, Thomas (Diane), Whitefish Bay; Neil, Fort Collins, Colo., and Michael, Milwaukee.

Lawrence R. Prouty, MD, 54, Madison, associate clinical professor at the University of Wisconsin Medical School, died Feb. 13, 1973 in Madison.

Born on June 6, 1918 in Denver, Colo., Doctor Prouty graduated from Cornell University Medical College in 1943 and served his internship and residency at Bellevue Hospital, New York City. He served in the United States Army during World War II and was an Air Force surgeon general consultant in internal medicine and cardiology at Truax Field for several years.

In 1953 Doctor Prouty joined the staff of the Quisling Clinic and in 1970 entered private practice in Madison. He was a member of the American Heart Association and Wisconsin Society of Internal Medicine.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are four children; Mark, Florida; Douglas, Lawrence R., Jr. and Susan, of Madison.

Charles H. Bachman, MD, 77, Milwaukee, died Feb. 14, 1973 in Milwaukee.

Born on Dec. 8, 1895 in Chicago, Ill., Doctor Bachman graduated from Marquette University School of Medicine in 1923 and served his internship at Milwaukee County General Hospital. Doctor Bachman served in the United States Army during World War I and was in the Milwaukee County Health Department for 20 years.

Surviving are his widow, Barbara and two children.

Herman H. Huber, MD, 73, Milwaukee, died Feb. 15, 1973 in Milwaukee.

Born on Sept. 14, 1899 in Milwaukee, Doctor Huber graduated from Rush Medical College and served his internship and residency at Mt. Sinai Hospital, Milwaukee. He was a former chief of staff of Mount Sinai Medical Center and retired in 1968. Doctor Huber also was a consultant on the surgical staff of Johnston Emergency Hospital and on the visiting staff of Columbia Hospital.

Surviving are his widow, Ethel; and two daughters, Mrs. Horton Newald and Mrs. Henry Good as well as a stepdaughter, Mrs. Robert Mandel, Milwaukee. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 12, 1973

NEW MEMBERS

Anderson, Calvin, 708 Vine St., Hudson 54016
Barrett, Joan M., 630 South Central Ave., Marshfield 54449
Beguin, Everett A., Jr., 1515 Tenth St., Monroe 53566
Camacho, Luis G., 59 Racine St., Menasha 54952
Chung, Kim Y., 1113 Main St., Oconto 54153
Davies, William B., 717 North East Ave., Waukesha 53186
Daza, Alfredo S., 1008 Byrd Ave., Neenah 54956
Hegedus, Stephen I., 630 South Central Ave., Marshfield 54449
Lee, Sang B., 705 Bay St., Chippewa Falls 54729
Mazza, Joseph J., 630 South Central Ave., Marshfield 54449
Melich, Paz Guidote, 152 West Second St., New Richmond 54017
Mielke, Donald J., 1111 Delafield St., Waukesha 53186
Price, David L., 2605 North Elmwood Ct., Appleton 54911
Rufino, Glicerio L., 516 Brazeau Ave., Oconto 54153
Saladar, Rafael S., 1732 Luety Parkway, Beloit 53511
Sierra, Jesus, 212 South 11th St., La Crosse 54601
Wernberg, Charles E., 645 Doctors Ct., Oshkosh 54901

CHANGE OF ADDRESS

Anderson, Gerhard R., 1101 Crystall Lake Dr., Pompano Beach, Fla. 33060
Banaszak, Edward F., 3249 South 18th St., Milwaukee 53215
Becker, Gary A., P. O. Box 603, Madison 53701
Bogle, Warren, 2400 Wippletree Lane, Brookfield 53005
Brazy, Robert B., 2147 West Skyline Rd., Milwaukee 53209
Caldwell, Richard B., 2629 Arboretum Lane, Madison 53713
Cassidy, George E., 233 Carillon Dr., Madison 53705
Cordero, Armenio C., 2219 South Gmeiner Rd., Appleton 54911
Dega, Francis J., Mayo Clinic, Rochester, Minn. 55901
de Guzman, Eleuterio A., W180 N8170 Destiny Dr., Menomonee Falls 53051
Denio, Martin J., Jr., 11622 West North Ave., Milwaukee 53226
Fick, Kenneth R., 15520 Apple Valley Ct., Brookfield 53005
Foerster, Harry R., Jr., 161 West Wisconsin Ave., Milwaukee 53203
Gascoigne, Clarence C., 6801 Pinella Point Dr., St. Petersburg, Fla. 33712
Glesne, Orvin G., 1222 Meadowcrest Dr., Mountain Home, Ark. 72653
Harbour, Jeanne D., 28 Oak Terr., Lake Bluff, Ill. 60044
Harris, John S., 506 East Longview Dr., Appleton 54911
Henske, William C., 803 Miles St., Chippewa Falls 54729
Hirsch, Samuel R., 836 N. 12th St., Milwaukee 53233
Mateicka, William E., 12606 Gremoor Dr., Elm Grove 53122
Miech, Michael J., 2211 Stout Rd., Menomonie 54751
Miller, Gerald J., 2763 Hagen Rd., La Crosse 54601
Miller, James E., 3510 Blackhawk Dr., Madison 53705
O'Connor, Thomas A., 1021 Spooner Rd., Milwaukee 53217
Olson, Albert P., II, 12033 Farnum, Omaha, Neb. 68134
Pittelkow, Robert B., 161 West Wisconsin Ave., Milwaukee 53203
Quitzon, Andres F., 6290 North Port Washington Rd., Milwaukee 53217
Regan, Joseph M., 8626 Jackson Park Blvd., Milwaukee 53226
Rhomberg, Bernard B., 9425 West Wisconsin Ave., Milwaukee 53226
Ruehlman, David D., 3618 Eighth Ave., Kenosha 53140
Russell, Thomas J., 161 West Wisconsin Ave., Milwaukee 53203
Salmon, Douglas D., 620 East Longview Dr., Appleton 54911
Schelble, Edward J., 2115 East Woodstock, Milwaukee 53202
Scrimenti, Rudolf J., 161 West Wisconsin Ave., Milwaukee 53203
Thiede, Walter H., 3249 South 118th St., Milwaukee 53215
Thompson, Thomas N., Jr., 4143 South 13th St., Milwaukee 53221
Trangsrud, H. Axel, 5000 West National Ave., Wood 53193
Tweeten, J. Kent, 333 West Mifflin St., Madison 53703
Wagner, William A., 830 Evans, Oshkosh 54901

DEATHS

Dryer, Raymond B., Columbia–Marquette–Adams County, Jan. 28, 1973
Murphy, James A., nonmember, Jan. 29, 1973
Arendt, Charles J., Wood County, Feb. 1, 1973
Sharpe, Harve Roy, nonmember, Feb. 3, 1973
Boyd, David L., nonmember, Feb. 5, 1973
Wolf, Frederick H., La Crosse County, Feb. 7, 1973
Sullivan, James M., Milwaukee County, Feb. 11, 1973
Prouty, Lawrence R., Dane County, Feb. 13, 1973
Bachman, Charles H., nonmember, Feb. 14, 1973
Huber, Herman H., Milwaukee, Feb. 15, 1973
Foerster, Harry R., Milwaukee County, Feb. 20, 1973
Way, Richard W., Dodge County, Feb. 25, 1973 □

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

How Supplied: Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.

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Varma A O *et al: Surg. Gynec. Obstet. 136*:281, Feb. 1973.

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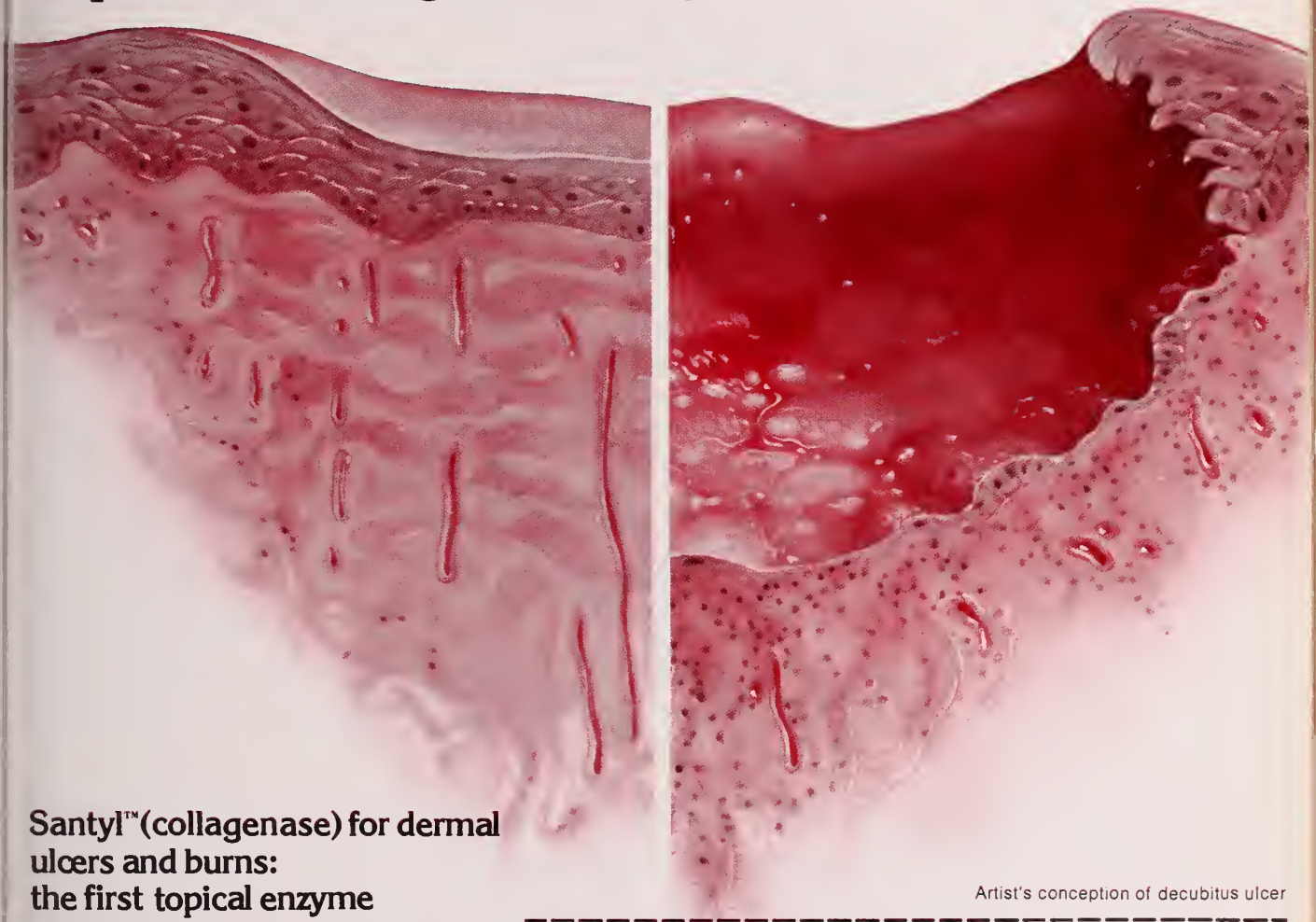

Artist's conception of decubitus ulcer

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City State Zip code

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia, drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and less often stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23261

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in two categories: PHYSICIANS EXCHANGE and COMMERCIAL. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. DISPLAY RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701; or phone (area code 608) 257–6781.

PHYSICIANS EXCHANGE

IMMEDIATE OPENING FOR AN ophthalmologist, family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write S. R. Lee, MD, President, or Russel Peterson, Clinic Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 11tfn

WANTED: GENERAL PRACTITIONER to join 3 young general practitioners in college community in southeastern Wisconsin. Two hospitals with 650 beds. Starting salary with progression to full partnership, vacation, sick leave, and profit-sharing benefits. Contact Dept. 374 in care of the Journal. 7tfn

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

WANTED: INTERNIST, BOARD certified or eligible. Beautiful northeast Wisconsin city of approximately 7000, 8-man mixed group, high standards, attractive working schedule, well equipped office. Extensive recreational facilities locally. Open salary, early partnership. Contact Dept. 387 in care of the Journal. p2–4/73

MULTISPECIALTY CLINIC IN northeastern Wisconsin is expanding; group seeking allergists, general surgeon, and internist. Ultramodern 500-bed hospital located close to the clinic. Excellent recreational area. Salary first year, corporate member thereafter. Small investment second year into corporation. Young group, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 378 in care of the Journal. 9tfn

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTITIONER to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

THE OSHKOSH CLINIC IS SEEKing associates in the following areas:

1. Allergy
2. General Practice
3. General Surgeon
4. Internal Medicine
5. Dermatology

This is an opportunity to join a 14-man Wisconsin group located in college community of over 60,000 with excellent hospital facilities. Summer and winter recreation unlimited. For further information, contact B. Greenwood, MD, Oshkosh Clinic, Oshkosh, Wis. 54901. p1/tfn/73

UROLOGIST: 4 YEAR SOLO. RElocate to avoid crosstown busing. Boards in progress. Desire area of demonstrated need. Wish solo, partner or associate. No groups or clinics. Contact Dept. 391 in care of the Journal. p4/73

STAFF PHYSICIANS: SEVERAL positions now available in a large state residential facility for the mentally retarded. Complete medical program, well-staffed and based in a recently constructed, modernly equipped 120-bed general hospital. Hospital includes diagnostic and evaluation, surgical, physical medicine, acute, chronic, and isolation units. Paramedical facilities include: EEG–EKG, X-ray, medical laboratory, pathology, pharmacy, occupational therapy, and physical therapy departments. Starting annual salary up to $30,300. Excellent fringe benefits. 40-hour week. Contact: L. M. Williamson, MD, Medical Director, at 414/878–2411, ext. 362, Southern Wisconsin Colony and Training School, Union Grove, Wisconsin. "An Equal Opportunity and Affirmative Action Employer." 4/73

WANTED EMERGENCY PHYSIcian full time to join group of three other physicians. City of 46,000 with excellent hospital facilities and location, recreational area and university. For further information contact Raymund J. Robbeloth, Executive Vice President, Sacred Heart Hospital, Eau Claire, Wis. 54701. Tel: 715/834–7731. 4/73

IMMEDIATE OPENING FOR:

1. Internist
2. Family Practice
3. Pediatrician
4. OB/GYN

To join young expanding group. New clinic and excellent hospital facilities adjacent to clinic. Excellent salary and partnership opportunities. New schools, churches and outstanding outside recreational activities. Contact: Lester Hirt, Box 127, Doctors for Medford, Medford, Wis. 54451. 4-6/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

NEEDED: INTERNIST OR GENeral practitioner to join board certified surgeon in two-man well established practice. Corporate advantages, $40,000 guaranteed first year. University community. Excellent recreation. A. J. Sowka, MD, 1525 Main St., Stevens Point, Wis. 54481. Tel: 715/344-4142. 4/73

EXCELLENT OPPORTUNITY: General practitioner needed in established practice. Modern clinic adjacent to 85-bed hospital. Progressive community of 6800, excellent schools and recreational facilities. Starting salary $32,000, partnership after first year. Phone, visit or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372–4177. p4-9/73

PHYSICIANS NEEDED: MULTIspecialty group of 24 specialists needs an:

1. Orthopedist
2. Otolaryngologist
3. Family Practitioner
4. Internist

Attractive income arrangements, association membership within 1 year, pension, and extensive fringe benefits. Excellent community of 50,000. Contact R. B. Windsor, MD, 1011 North 8 St., Sheboygan, Wis. 53081. Tel: 414/457-4461. 4-6/73

WANTED: INTERNIST, GP TO join expanding mixed specialty group in Green Bay. New clinic building and excellent hospital facilities. Contact R. J. Murphy, MD, Deckner Medical Center, 1751 Deckner Ave., Green Bay, Wis. Tel: 414/435–8301. p9/tfn

RADIATION THERAPY RESIdency—Two positions available in July '73. Approved 3-year program designed to develop competence in clinical oncology, radiation biology, radiation physics in major modern teaching hospital. Direct applications to Director of Radiotherapy, University of Texas Medical Branch, Galveston, Tex. We are an Equal Opportunity Employer. 2–4/73

GENERAL PRACTICE. LIVE AND work in northwestern Wisconsin vacationland. Corporate general practice expanding to 8. If interested, call or write: F. M. Bannister, MD, Chetek, Wis. 54728. Tel: 715/924–4811. 3–8/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468–2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3–8/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

DIRECTOR
OF
MEDICAL
EDUCATION

Large, voluntary, general hospital located in Chicago, offers an excellent opportunity for a full time Director of Medical Education. Prefer a physician experienced in coordinating residency programs, University/Community hospital relationships and inhospital postgraduate education programs. Competitive salary and excellent benefits. Consulting privileges considered. Submit resumé to:

Chairman, DME Search Committee

HOLY CROSS HOSPITAL
2701 W. 68th Street
Chicago, Illinois 60629

WANTED—GENERAL OR FAMILY practitioner to join 3-man group. 45-bed hospital in community. 35 miles from St. Paul. Baldwin Clinic, S.C., Baldwin, Wis. 54002. Tel: 715/684–3326. 10–5

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

WANTED: GENERAL PRACTItioner, preferably with surgical and obstetrical experience. Ready made practice. No investment. Senior partner retiring. Junior partner desires associate. Ideal midwest college town for family. All educational, recreational, religious, medical and dental facilities readily available in community. Contact Dept. 370 in care of the Journal. 5tfn

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

WANTED: FAMILY PHYSICIAN—eight man mixed group northeast Wisconsin, small city in fertile fishing, hunting, outdoor recreational area, lake and river. Very attractive facilities and call schedule, 84-bed municipal hospital. Open salary, early partnership. Contact Dept. 386 in care of the Journal. p2–4/73

IMMEDIATE OPENING FOR INternist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545; tel: 1–608/752–7811. 4tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

GENERAL PRACTITIONER WITH strong interest or background in industrial medicine needed by eleven-man multispecialty clinic. Full time or part time. Salary negotiable, many fringe benefits. Asssociate status possible after one full calendar year. Contact: Administrator, Medical–Surgical Clinic, S. C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215. 2–5/73

WANTED: DOCTOR (SEMIretired) interested in part time work assisting group in gynecological work in Milwaukee area hospital. Must be licensed in State of Wisconsin. Contact Dept. 389 in care of the Journal. 3–5/73

GENERAL PRACTITIONER wanted to share the good life in beautiful KEWAUNEE, Wis. We can offer you, an accredited hospital, office and clinic space, crime free community, good schools, three fine churches, beautiful homes, beautiful people, Lake Michigan with its fabulous trout fishing, water skiing, boating, snowmobiling, skiing, golfing and the PACKERS. Packer Country is just 25 miles west and lastly—MONEY. Per capita income is high. We see our doctor and we pay our bills. Write to: Doctor Search Committee, P. O. Box 222, Kewaunee, Wis. 54216. 3tfn/73

INTERNIST OR GP: COUNTY Mental Hospital awakening to its role as comprehensive mental health center needs physician to enlarge and implement the development of a program to meet the medical care aspects of total treatment program. Modern Medicare-certified extended care facility part of complex. New 292-bed mental hospital under construction, scheduled for spring completion, includes abundant space for medical clinic. Staff membership at community general hospital encouraged. Progressive city of 50,000 gateway to Northwoods, excellent schools, outstanding parks, expressway access to Madison (45 minutes), Milwaukee (80 minutes), and Chicago (90 minutes). Excellent opportunity to meet challenge at your own pace with minimum of pressure. Salary $27,000, liberal fringe benefits. Administrator, Rock County Hospital, Box 351, Janesville, Wis. 53545. 2tfn

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living; discover Watertown, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy going pace of a residential city.

We urgently need family practitioners, internists and other specialties; exceptional opportunities for private or group practice growth.

Our new community health care center with its beautiful 110-bed general hospital, connecting (but separate) 24 unit medical–dental office building and connecting 120-bed nursing home, was completed in 1971.

Watertown is a progressive community, ideally located equi-distant between Milwaukee and Madison in southeastern Wisconsin's lake district; the community has a trade and medical practice area serving 40,000 people; many new schools, parks, trees, social and recreational facilities; a stable economy.

Enjoy the best of two worlds: practice in a tree-shaded medium size city with access to the medical centers at the University of Wisconsin and the Medical College of Wisconsin (formerly Marquette University School of Medicine). The medical staff is leading and supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261–4210. 3tfn/73

WELL TRAINED PATHOLOGIST, AP (CP eligible), excellent references, special training in oncologic pathology, military service completed, seeks position as associate pathologist or as director. Contact Dept. 393 in care of the Journal. 4tfn/73

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial–agricultural community with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693–3021. This ad endorsed by present doctor. 2–7/73

CAN A YOUNG FAMILY PRACTITIONER find: medical, social and economic happiness in "THE NORTH WOODS"? Soap Opera? Not quite! It's all here in Eau Claire, Wis. We're all GPs and we'll be moving in a new office. Don't blame us if you get here too late! Write: G. G. Giffen, MD, Putnam Heights Clinic, P.O. Box 970, Eau Claire, Wis. 54701. 2–6/73

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

WANTED: FAMILY PRACTITIONERS and internists to join 20-man mixed specialty clinic. Teaching opportunities guaranteed. Salary with corporate ownership in two years. William Rock, MD, East Madison Clinic, 1912 Atwood Ave., Madison, Wis. 53704. 6–5

PRACTICES AVAILABLE

MILWAUKEE: QUALITY INTERnal medicine practice in lovely suburban shopping center. Grossing $83,000 and netting $64,000. Excellent opportunity. Financing available.

OTHER EXCELLENT PRACTICES available throughout Wisconsin, Illinois and Indiana. No fee to buyers. Financing available. Strictly confidential. Free brochure. PROFESSIONAL PRACTICE SALES, 540 FRONTAGE RD., NORTHFIELD, ILL. 60093. Tel: 312/441–6111. 4/73

LARGE PRACTICE AVAILABLE: Before you make any decision please see this practice. Good for two GPs. Do surgery, GP, OB-GYN. Well built and furnished practice. All recreation available right here with hospital in town. Contact Dept. 392 in care of the Journal. p4-5/73

GENERAL PRACTICE FOR SALE: South Central Wisconsin city of 6500, drawing area of 17,000. Thirty years established practice. $65,000 to $70,000 gross income . . . net $40,000 to $45,000. Excellent hospital facilities. Fully equipped office . . . competent secretary–receptionist and nurse. Contact A. J. Harris, MD, 112 W. Oak St., Sparta, Wis. 54656. Tel: 608/269–3115. 3tfn/73

MEDICAL FACILITIES

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g4tfn/73

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

FOR LEASE. SHEBOYGAN, WIS. Suite, at present occupied by oral surgeon. Available May 1, probably earlier. Other occupants are a physician and dentist. Suitable for any medical or dental specialty. Later purchase of building possible. For details write to Dept. 383 in care of the Journal. 1tfn/73

FOR SALE: MEDICAL BUILDING. 2100 square feet. Two divided suites. Separate, central gas heat and air conditioning. Paved parking lot. Excellent location. Residential area. Five minutes from either hospital. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634–6833. 3tfn/73

COMMERCIAL

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

WANTED: USED MICROSCOPES. Nicaragua/Wisconsin Partners of the Alliance have requests for used microscopes suitable for use in Nicaraguan high schools for teaching purposes. Donations to the Partners are tax deductible. Please notify Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701, if you have a usable microscope. g5tfn

PUBLICATIONS

The Rights of Teenagers as Patients. Do minors have the right to seek out and obtain needed medical services without having to get the approval of their parents? Is a teenager entitled to confidentiality when he requires treatment to restore or preserve his health? Or should parents have the right to consent to—or deny—health services for their child?

These vital questions behind the growing freedom of young people to seek medical treatment are considered in THE RIGHTS OF TEENAGERS AS PATIENTS by Theodore Irwin, a new Public Affairs Pamphlet. Mr. Irwin considers the "why" behind demands for "teenage lib" in health matters, the complexities of state laws relating to teenagers as patients, the kinds of medical care adolescents require most urgently, and new health services specifically designed to meet those needs. THE RIGHTS OF TEENAGERS AS PATIENTS (No. 480) is available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

Symposium on Aging. A symposium presented in FORUM, the Wisconsin Psychiatric Institute publication, distributed biannually. This *Symposium On Aging* consists of contributions from writers who represent varied fields—all having a special interest in the older person. Available thru the Wisconsin Psychiatric Institute, 1300 University Ave., Madison, Wis. 53706. 1/73

Plain Talk About Child Abuse. The six articles in this pamphlet are reprinted with permission from *The Denver Post.* They provide an overview of the multi-faceted problem of child neglect and abuse. Published by the Children's Division of the American Humane Association, the publication provides clear and succinct interpretation of the nature and dimensions of the problem of neglect and abuse; it explores causation; and it develops a rational philosophy for treatment of causes and effects. Price: 35 cents from AHA, PO Box 1266, Denver, Colo. 80201.

The Hospital and the Home Care Program. Published by the American Hospital Association, supersedes the 1966 publication entitled *Hospitals and Coordinated Home Care Programs.* Available from AHA, 840 North Lake Shore Drive, Chicago, Ill. 60611.

Guide for School Health Examinations. 40-page, 1970 revised edition, prepared and published by the State Medical Society's Division on School Health in cooperation with the Wisconsin State School Health Council, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, at cost of $1.00 per copy to be sent with order.

GUIDELINES FOR BLOOD–ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

ANNOUNCEMENTS

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20–21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

INTERESTED SMS MEMBERS may obtain from the AMA a copy of a new, 185-page AMA paperback which consists of brief information on approximately 200 medical topics, plus references to AMA activities, policies and publications in each field. Send $1 per copy to AMA, 535 N. Dearborn St., Chicago, Ill. 60610. The reference book is available at 50¢ to medical students, interns, and residents. 4/73

ALL PSYCHIATRISTS WHO HAVE not already taken the Psychiatric Knowledge and Skills Self-Assessment Program (PKSAP), are urged to apply for it by writing to the APA, 1700 18th Street, N.W., Washington, D.C. 20009. The test stresses patient management problems, allows participants to score themselves in relation to peers, and earns credits for continuing medical education. 4/73

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS: The health care delivery system is on short notice to demonstrate effective internal controls over the quality and costs of its services, or to be prepared to live with an externally imposed and bureaucratically administered control system. In response, the revised standards of the Joint Commission mandate that hospital boards, administration and organized medical staffs implement programs to assure the quality and cost effectiveness of all care rendered for both inpatients and outpatients.

The Joint Commission and its parent organizations—the American College of Physicians and of Surgeons, the AMA and the AHA—believe that the quality assurances demanded by the Standards will be effective in satisfying the demands of the consumer movement and its political supporters for public accountability. The Standards—by reaffirming the ultimate responsibility of the hospital governing authority, whose members are selected from, representative of, and accountable to the community served by the hospital—present a system in which control of the quality remains professional, local and internal to the hospital, while still functioning in the context of the public accountability insisted upon by the consumer movement.

The TAP Institutes (Trustees, Administrators, Physicians) sponsored by the Joint Commission, translate these quality requirements into practical, realistic hospital credentialling and medical audit systems. They will advise key medical staff, administrative and board personnel in how to conduct and document an internal quality assurance program that will, by conforming to the Standards, qualify a hospital to become or to remain accredited and at the same time satisfy the broad policy demands of the public.

Therefore, at issue is not only the accreditation status of the individual hospital, but also the future direction that the entire voluntary health care delivery system will take.

The TAP Institute schedule for the remaining of 1973 as of August 1, 1972, is set forth below; additional sessions will be announced as they are added to the schedule.

May 4–6: Ocean City, Md.
May 11–13: Lake of the Ozarks, Mo.

CURRENT PERINATAL INFORMATION IN DIAL ACCESS LIBRARY. The Wisconsin Dial Access Tape Library is a source of immediate practical information for doctors and nurses providing perinatal care. Over 40 tapes are now available dealing with such problems as abruptio placenta, bacteremic shock, respiratory distress syndrome, hypoglycemia of the newborn, etc. Tapes are continually revised by the authors. This service is available to physicians for a $25 subscription fee. Nurses can utilize this service free of charge. For further information and a complete list of dial access tapes write: Dial Access Library, 610 North Walnut Street, Madison, Wis. 53706.

ORDERS for Emeritus Dean William S. Middleton's new book, "Tangible and Intangible Values in Modern Medicine," are now being accepted by the Wisconsin Medical Alumni Association office. The 300-page book contains a collection of Doctor Middleton's 35 best nonclinical writings — articles and speeches that he has presented to medical and lay audiences over the past several decades. Cost: $11.50. Contact Mrs. Froland in the Medical Alumni office, 610 N. Walnut, Madison. Tel. 608/263–4914.

The services of a professional registered nurse, licensed practical nurse, licensed vocational nurse, or technical registered nurse outside an inpatient facility are payable as CHAMPUS outpatient benefits when the attending physician certifies that the services are medically necessary.

Under CHAMPUS maternity care is considered to encompass the prenatal care episode, the delivery, the postnatal care episode and the treatment of complications arising out of the pregnancy. It also includes the care of the newborn infant during the post-delivery confinement of the infant's mother.

WISCONSIN PROFESSIONAL SOCIETY ON ADDICTIONS. Membership in the Wisconsin Professional Society on Addictions is open to those who are in a position of directing, administering or coordinating councils, information and referral centers, clinical settings for alcoholism or drug abuse or their divisions who have submitted a written application for membership. Membership fee is $10 annually. Applications should be sent to: William Roberts, 4200 Marquette Drive, Racine, membership chairman. John W. Sell is president of the society whose primary purpose is "to foster coordination, insure cohesiveness and upgrade effectiveness within the information–referral centers throughout the state."

FILMS

Thyroid Disease as a Late Sequela of Radioactive Fallout is the title of a new film from the Flint Laboratories division of Baxter Laboratories, Inc. The 30-minute, full color–sound film was produced by Flint in conjunction with Brookhaven National Laboratory and the Atomic Energy Commission. It specifically covers the subject of thyroid disorders as related to accidental fallout of radioactive iodine on the people of Rongelap Island in 1954. The film has won the Gold Camera, Cine, and New York Film Festival awards. Booking arrangements may be made through: Professional Services Department, Flint Laboratories, 200 Wilmot Road, Deerfield, Ill. 60015.

The Heritage of Operating Room D. A new, full-color motion picture which interweaves the history of surgery, anesthesiology and anatomy around a present-day open heart operation has been produced for Parke, Davis & Company, a subsidiary of Warner–Lambert Company. The 27½-minute film tells the story of three-year-old Lynda's successful surgery in which a hole in the heart area is repaired with a Teflon patch. Narrated by stage and screen star Jose Ferrer, the drama is played out in the present, but "peopled" with characters from the past whose medical triumphs made possible Lynda's operation.

Through live and computerized animation stand photography, the viewer sees the historical development of the conquest of pain, of anesthesia, of antiseptic cleanliness, and of surgical skill from the dawn of civilization to the present.

The film also uses 14 of the Parke–Davis Great Moments in Medicine oil paintings to help tell the story of medical discoveries and historical development. "The Heritage of Operating Room D," available through Modern Talking Pictures, was produced by Medical Vistas, and written and directed by Al Wasserman, of New York.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

May: Annual Meeting, Wisconsin Clinic Managers. (Note that this will not be held in conjunction with the Annual Meeting of the State Medical Society as in past years.)

May 4: Spring Conference, Wisconsin Association of Alcohol and Other Drug Abuse, Howard Johnson Motel, Fond du Lac.

May 5: Neurology and Neurosurgery Course for Family Practitioners and Other Specialists, sponsored by the Department of Neurosurgery through the Division for Health Professions Education of the Medical College of Wisconsin, at the Marriott Inn, Brookfield.

May 9: Family Practice Conference, Neenah.

May 9: Spring Refresher Seminar of the Wisconsin Academy of Family Physicians, St. Vincent's Hospital, Green Bay.

May 10: Family Practice Conference, Wausau.

May 11–12: University of Wisconsin Alumni Weekend, Madison.

May 16: Family Practice Conference, Eau Claire.

May 21–22: Workshop for occupational therapists and other professionals interested in learning disabilities and sensorimotor dysfunctions in children, Madison. Sponsored by the Wisconsin Committee for Continuing Education in Sensory Integration in collaboration with the Center for the Study of Sensory Integrative Dysfunction, Pasadena, Calif.

May 30–31: Symposium on Peptide Synthesis, at The Wisconsin Center on the University of Wisconsin–Madison Campus, Madison. Info: Theo Gerritsen, DSc, Postgraduate Medical Education, WARF Bldg., 610 Walnut St., Madison 53706.

June 14–16: Reproductive Endocrinology Conference, UW Center for Health Sciences and UW Extension, Wisconsin Center, Madison.

June 13–14: Annual Meeting, Wisconsin Regional Medical Program, Pioneer Inn, Oshkosh.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

July 29–Aug. 3: Symposium on Alcoholism and Other Drug Abuse, Mt. Senario College, Ladysmith (endorsed by the Education Committee of the Wisconsin Academy of Family Physicians for 33 hours of postgraduate credit).

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

1973 NEIGHBORING STATES

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

May 9–12: Seventeenth Postgraduate Course on Fractures and Other Trauma, Chicago Committee on Trauma of the American College of Surgeons, Sheraton–Chicago Hotel, Chicago, Ill.

May 13–15: Great Plains Organization for Perinatal Health Care, Thunderbird Motel, Minneapolis, Minn.

May 24–25: Minnesota State Medical Association Annual Meeting, Raddison South, Minneapolis.

Jun 1: Emergency Cardiac Care Symposium, Iowa Heart Association, Johnny & Kay's Hyatt House, Des Moines. Info: Iowa Heart Association, 529—36th St., Des Moines, Ia.

June 10–15: 1973—Midwest Institute on Alcoholism, Western Michigan University, Kalamazoo, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

May 4–5: Annual Conference, British Columbia Oto-Ophthalmological Society, Hotel Vancouver, Vancouver, B.C.

May 9–10: Advances in Dermatology, postgraduate course of Cleveland Clinic Educational Foundation, Cleveland, Ohio.

May 12: Gastrointestinal Endoscopy: Techniques and Applications, postgraduate course of Cleveland Clinic Educational Foundation, Cleveland, Ohio.

May 16–18: Advances in Pediatric Radiology, Emerson Auditorium, Indiana U, Indianapolis.

May 20–25: Hospital Medical Staff Conference, Sun Valley, Idaho. Info: Northwest Hospitals Education and Research Alliance, % Oregon Association of Hospitals, 220 S.W. Morrison St., Portland, Ore. 97204; tel. 503/228–5608.

May 20–26: American Gastroenterological Association postgraduate course, *Cirrhosis and Portal Hypertension* as part of Digestive Disease Week. Americana Hotel, New York. Info: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N. J. 08086.

May 21–24: Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Bal Harbour, Fla.

May 29–31: Postgraduate seminar *Master Interpretation of Clinical Electrophysiology* sponsored by University of Miami School of Medicine and Council on Clinical Cardiology of the American Heart Association. Contemporary Hotel at Disney World, Lake Buena Vista, Fla. Info: Dr. Louis Lemberg, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

June 11–16: General Practice Review, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

June 14: Eighth Annual Continuation Course on "Clinical Electroencephalography," Statler–Hilton Hotel, Boston, Mass. Info: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55901.

June 15–16: Annual Meeting, American Electroencephalographic Society, Statler–Hilton Hotel, Boston, Mass. Info: Mrs. Margaret H. Henry, Exec. Secy., American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

June 21–23: Postgraduate Course on Newborn Problems, Disney World, Lake Buena Vista, Fla. Sponsored by the American Academy of Pediatrics and presented by the U of Florida, College of Medicine.

July 16–20: Internal Medicine, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

July 26–28: Postgraduate Course on Biliary Tract Disease, American Gastroenterological Association, Playhouse, Aspen, Colo.

July 29–Aug. 1: Pediatrics, U of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Aug 2–4: Fifth Aspen Conference for Dermatologists, Rocky Mountain Dermatological Society and University of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Sept. 19–22: District V, American College of Ob–Gyn, Pantland Hotel, Grand Rapids, Mich.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

MEDICAL MEETINGS . . .

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov 29–Dec 1: National Conference on Virology and Immunology in Human Cancer, Waldorf–Astoria Hotel, New York, N. Y. Sponsored by American Cancer Society and National Cancer Institute.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

June 24–28: Annual Convention, New York.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

1974 NEIGHBORING

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

Oct. 21–25: Clinical Congress, American College of Surgeons, Miami Beach, Fla.

* * *

Family Physician Spring Refresher Seminars, St. Vincent's Hospital, Green Bay, Wednesday, May 9. Meeting acceptable for seven hours of prescribed credit by American Academy of Family Physicians. Open to all physicians. Seminars begin at 9:00 a.m. and conclude at 5:00 p.m. Luncheon for all participants at noon. Info: Wisconsin Academy of Family Physicians, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

Neurology and Neurosurgery Course for Family Practitioners and Other Specialists. One-day symposium, Saturday May 5, at the Marriott Inn, Brookfield. Designed to sharpen the neurological skills of family practitioners and other specialists. Offered by the Department of Neurosurgery through the Division for Health Professions Education of the Medical College of Wisconsin.

Dr. William S. Fields, chairman of the department of neurology, University of Texas, has been invited to participate in the program along with MCW neurologists, neurosurgeons, and related specialists.

Some of the topic sessions to be covered include streamlined neurological examination, stroke management, early management of spine injuries, drug therapy of epilepsy and meningitis, electro stimulation of pain relief, automated patient monitoring and extracranial vascular occlusion disease. Problems presented by family practitioners also will be discussed.

Course is approved by the American Academy of Family Physicians for six credits.

Further info: Department of Neurosurgery, The Medical College of Wisconsin, 8700 West Wisconsin Avenue, Milwaukee, 53226 (Tel. 414/258–2040, ext. 2338) or the Division for Health Professions Education, The Medical College of Wisconsin, 561 North 15th St., Milwaukee, 53233 (Tel: 414/272–5450, ext. 320).

Short Refresher Course in Occupational Medicine. Sponsored by Department of Preventive Medicine, University of Wisconsin–Madison and American Academy of Occupational Medicine, June 1–2, Wisconsin Center, 702 Langdon Street, Madison.

Symposium will update physicians in several highly important and selected fields of occupational medicine. Emphasis will focus on practical topics of greatest current concern including clinical discussions. All physicians, particularly family physicians, and other specialists who serve industry on a part-time or other basis will be especially interested.

Topics: ADMINISTRATIVE FACTORS—the part-time physician and the Occupational Safety & Health Act (OSHA), NIOSH (National Institute of Occupational Safety and Health) (purpose, functions, relationships to physicians engaged in occupational medicine), pre-employment and periodic examinations (discuss basis for certain mandatory exams), trends in Workmen's Compensation—state, trends in Workmen's Compensation—national, industrial hygiene activities to assist physicians;

CLINICAL OCCUPATIONAL MEDICINE—occupational diseases (hypersensitivity lung diseases, polymer fume fever, isocyanate inhalation, asbestosis), occupational skin contactants, noise and hearing conservation, work physiology (definition of degree of intensity of work "light," "moderate," "heavy") heat stress, low back problems, lead—case presentations ("borderline" and not so "borderline"), an unknown clinical case presentation, and group discussion and participation.

Course coordinators: Drs. Vernon Dodson, John Rankin, and Carl Zenz. Preregistration: $20 (includes luncheon and dinner). No registration fee required from students, interns, and residents. Enrollment limited to 75. Course approved for 9 credit hours by AAFP.

Further info: Carl Zenz, MD, Medical Director, Allis–Chalmers Corp., P.O. Box 512, Milwaukee, Wis. 53201; tel. 414/475–4566.

Wisconsin Heart Association Annual Scientific Sessions for physicians and nurses, June 9, at the Marriott Inn, Milwaukee.

Topic of the day-long symposium is "The Role of Exercise in Heart Disease." General sessions in the morning will be followed by a series of panel discussions in the afternoon. Wisconsin Heart's annual dinner and meeting for business will be held at the Marriott Inn that evening.

Emergency Cardiac Care Symposium. June 1, sponsored by the Iowa Heart Association at Johnny & Kay's Hyatt House, Des Moines, Iowa. For practicing physicians, nurses, and related medical personnel in Iowa and surrounding states. Info: Iowa Heart Association, 529—36th Street, Des Moines, Iowa 50312.

Biliary Tract Disease. Postgraduate course of American Gastroenterological Association, July 26–28 at the Playhouse, Aspen, Colo.

Course objective: to bring the practicing physician up to date on recent advances in the pathophysiology, diagnosis, and treatment of biliary tract disease. Consists of three half-day sessions, each of which will combine lectures and discussions to cover both basic science and clinical topics.

First day will be devoted to bile secretion and cholestasis, and will cover the physiology and pathophysiology of bile secretion, bilirubin formation and secretion, causes and consequences of cholestasis, and the treatment of cholestasis and hyperbilirubinemia in infants and adults.

Second day will be devoted to cholelithiasis and gallbladder disease and will cover recent advances in our understanding of the mechanisms involved in gallstone formation, and recent work demonstrating how this process can be influenced by inducing alterations in bile composition.

Final day will be concerned with diseases of the bile ducts, and will include a discussion of newer methods in the diagnosis of obstructive jaundice, the medical and surgical treatment of retained gallstones, and clinical aspects of cholangitis.

Course is designed primarily for physicians in general practice, internal medicine, surgery, and pediatrics with a strong interest in liver disease and gastroenterology. However, gastroenterologists and trainees wishing to review this area are also welcome. The course

will not be directed to investigators in these fields.

Course is approved for 12 hours prescribed credit by the American Academy of Family Physicians.

Reproductive Endocrinology Conference, June 14–16 at Wisconsin Center on University of Wisconsin–Madison campus.

Program, sponsored by UW Center for Health Sciences and the UW Extension, will be a series of panels and workshops to acquaint physicians with recent advances in endocrinology. Sessions will give attending physicians opportunity to meet in a number of small group discussions with leaders in the field.

Topics will include female endocrine problems, reproductive genetics, infertility, contraceptive problems and postmenopausal endocrinology. Conference will serve as both a review of the important aspects of endocrinology and as an aid to physicians in offering better care to patients that require this type of medical attention.

Among the guest speakers will be Prof. Charles Lloyd, chief of reproductive biology at the Milton S. Hershey Medical Center, Hershey, Pa.; Prof. Luigi Mastroianni, chairman of obstetrics and gynecology at the University of Pennsylvania; and Sheldon Segal, PhD, director of the Bio-Medical Division of the Population Council, New York City.

Also featured among the speakers will be 10 members of the University of Wisconsin medical faculty, including professors Ben M. Peckham, chairman of obstetrics–gynecology; Dolores Buchler and Gloria Sarto, both of obstetrics–gynecology; John Opitz, pediatrics and medical genetics; Antonio Colas, gynecology–obstetrics and physiological chemistry; and Frank Larson, director of clinical laboratories.

Further information on the conference and a complete list of the speakers and discussion topics may be obtained from the Department of Postgraduate Medical Education, 610 Walnut St., Madison 53706.

Symposium on Alcoholism and Other Drug Abuse is set for Sunday, July 29, through Friday, August 3, at Mt. Senario College in Ladysmith. Aimed particularly for the rural health and helping professionals. Endorsed by the Education Committee of the Wisconsin Academy of Family Physicians for 33 hours of postgraduate credit. Physicians or health professionals will be housed in one of the college dormitories or may stay at a nearby hotel–resort.

Among the speakers will be Dr. Joseph Benforado of Madison and Dr. Dan Anderson of Hazeldon Treatment Center, Center City, Minn.

Early registrations are being accepted. Correspondence should be directed to Dean Edwin Blackburn, Mt. Senario College, Ladysmith, Wisconsin. There is a $5.00 registration fee, plus $40.00 for the five-day workshop. Includes room and board and use of classroom facilities and equipment.

D. J. Flogstad, MD of Shell Lake is a member of the steering committee which is composed of representatives of Wisconsin and Minnesota state agencies and other educational and health-related institutions and organizations.

National Conference on Virology and Immunology in Human Cancer. Sponsored by American Cancer Society and National Cancer Institute, Nov. 29–Dec. 1 at the Waldorf–Astoria Hotel, New York, N. Y.

Purpose of Conference is to present to the medical and related professions the current developments in research and clinical investigation in virology and immunology and the assessment and implications of this work in the prevention and treatment of human cancer.

Sessions are open to all members of the medical and related health professions. Pre-registration is requested. No registration fee. Info: Sidney L. Arje, MD, National Conference on Virology and Immunology in Human Cancer, ACS, Inc., 219 East 42nd St., New York, N. Y. 10017. □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

National Institute of Mental Health Task Force on Homosexuality: Final Report and Background Papers. Edited by John M. Livingood, MD. National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. 79 pages. Price: 75¢

Not the Law's Business? By Gilbert Geis, PhD. National Institute of Mental Health, Center for Studies of Crime and Delinquency, 5600 Fishers Lane, Rockville, Md. 20852. 1972. 262 pages. Price: $1.50

Social Change and Human Behavior. Edited by George V. Coehlho and Eli A. Rubinstein. National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. 1972. 237 pages. Price: $2.00

Mental Health and Learning. U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. 1972. 68 pages. Price: $1.25

Current Diagnosis and Treatment. By Marcus A. Krupp, MD and Milton J. Chatton, MD. Lange Medical Publications, Los Altos, Calif. 1973. 996 pages. Price: $12.00

Vasectomy, Sex, and Parenthood. By Norman Fleishman and Peter L. Dixon. Doubleday & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 128 pages. Price: $5.95

Surgery in World War II. Medical Department, United States Army. Office of the Surgeon General, Department of the Army, Washington, D.C., 1970. Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402. 1099 pages. Price: $12.95

Mental Health and Social Change. National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. 1972. 458 pages. Price: $3.00

Electronics for Medical Personnel. By Edward J. Bukstein. Howard W. Sams & Co., Inc., 4300 West 62nd St., Indianapolis, Ind. 46268. 1972. 144 pages. Price: $4.95

The Crisis Team. By Julian Lieb, MB, BCh, Ian I. Lipsitch, MD, and Andrew E. Slaby, MD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1973. 186 pages. Price: $6.95

The Limbic System: Anatomy and Physiology. Roche Laboratories, Division of Hoffmann–La Roche Inc., Nutley, New Jersey 07110. 38 pages

Drug Abuse: Everybody's Problem. American Social Health Association, 1740 Broadway, New York, N. Y. 10019. 63 pages

State Statutes on Emergency Medical Services. U. S. Department of Health, Education, and Welfare. Health Services and Mental Health Administration, Division of Emergency Health Services, 5600 Fishers Lane, Rockville, Md. 20852. May 1972. 192 pages

BOOK REVIEWS

Rehabilitation Medicine.

By Howard A. Rusk, MD, The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 687 pages. Price: $21.00.

This third edition, following the same general format as the first edition published in 1958, has expanded sections on the rehabilitation of patients with cardiovascular disease, cerebrovascular disease, cancer and chronic obstructive lung disease. The sections on prosthetics and orthotics have been enlarged and are well illustrated.

The book is written primarily for physicians and has chapters on the evaluation process, principles of physical medicine, physical therapy and occupational therapy and rehabilitation nursing. The chapter on physical medicine discusses the modalities of heat, ultraviolet, direct current, low frequency currents, and massage. The use of cold has not been changed from the first edition. The chapter on physical therapy discusses the uses of therapeutic exercise and the chapter on occupational therapy is concerned with activities of daily living.

The second half deals with the rehabilitation of patients with acute and chronic disorders. Although this book

CONTRIBUTIONS—CES FOUNDATION

February 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1973:

Unrestricted

905 SMS members voluntary contributions

Restricted

4 SMS members voluntary contributions, Anonymous—*Museum of Medical Progress*
48 SMS members voluntary contributions—*Student Loans*
78 SMS members voluntary contributions—*Charitable—Disabled Physicians*
George R. Andrews, MD; Arthur B. Grant, MD
4 SMS members voluntary contributions; Merck & Co., Inc.; Watertown Memorial Hospital—*Scientific Teaching/General*
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BOOKSHELF . . .

was written for physicians, it would be a helpful reference for physical therapists, occupational therapists, nurses, speech therapists, and vocational rehabilitation counselors.—MARY JANE MENG, BS

Lasers in Medicine.

By Leon Goldman, MD and R. James Rockwell, Jr. Gordon and Breach, Science Publishers, Inc., 241 Taaffe Pl., Brooklyn, N. Y. 11205. 1971. 385 pages.

This book is an expansion of an earlier book by the senior author dealing with lasers in medicine. The senior author, Leon Goldman, is a physician who has had many years experience with applications of lasers in medicine. The second author, R. James Rockwell, is a physicist who has been working with lasers in medicine for about eight years. This combination of authors results in a comprehensive text which covers both the physical and medical aspects of the subject in detail.

The first three chapters give a good explanation of lasers, their development, characteristics, and instrumentation used to measure laser radiation. Two chapters then deal with biological reactions to laser light. It also has chapters on holography and laser safety. Four chapters deal explicitly with clinical investigations and applications of lasers in areas of ophthalmology, dermatology, and cancer research.

Like all new physical techniques that have applications in medicine, there often is a tendency to give excessive publicity to devices such as the laser. The authors present a very sound discussion of its capabilities and limitations. In the opening paragraph of Chapter 1 the authors state that it is a basic and practical axiom in the study of applications of lasers that "if you don't need the laser, don't use it."

The book should serve as an excellent reference for any person considering the use of lasers in medicine. The chapter on a laser safety program should be required reading for all safety officers in medical centers, industrial plants, universities, etc. wherever lasers are used.

This book belongs on the bookshelf of every medical scientist who is now using or plans to use lasers.—JOHN R. CAMERON, PhD □

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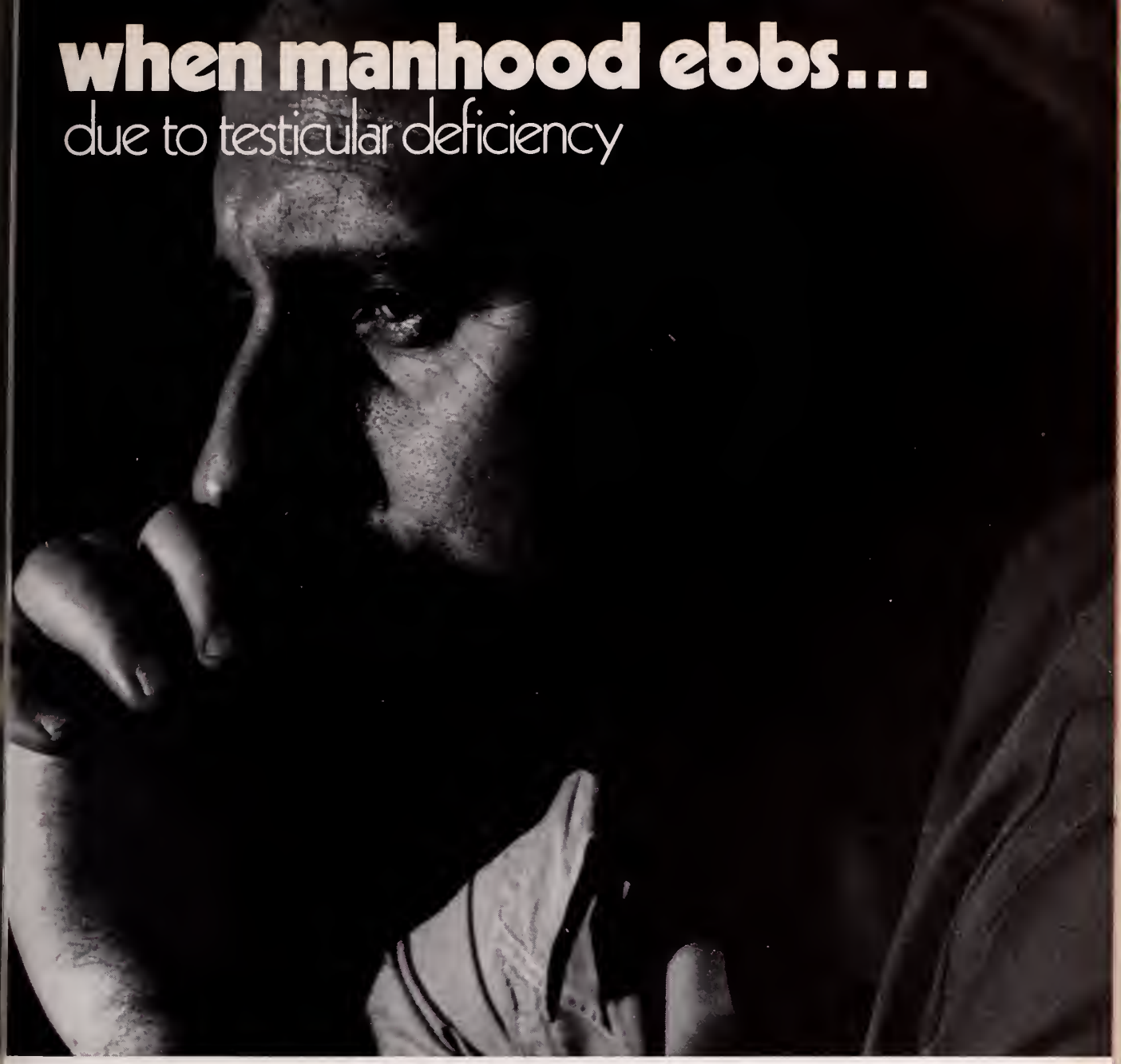

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Indications in the male: Primary indication in the male is replacement therapy. Prevents the development of atrophic changes in the accessory male sex organs following castration:
1. Primary eunuchoidism and eunuchism. **2.** Male climacteric symptoms when these are secondary to androgen deficiency. **3.** Those symptoms of panhypopituitarism related to hypogonadism. **4.** Impotence due to androgen deficiency. **5.** Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.
In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. **2.** Palliation of androgen-responsive, advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.
Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.
Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.
Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.
Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.
How Supplied
2 mg—bottles of 100 scored tablets.
5 mg—bottles of 50 scored tablets.
10 mg—bottles of 50 scored tablets.
For additional product information, see your Upjohn representative or consult the package circular.

MED 8-6-S (MAH)

JA71-1008R

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How strong must a tranquilizer be for severe anxiety?

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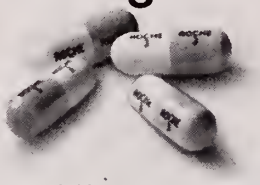

For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

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Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age require that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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nificant weight gain or edema. A one-week
is adequate. Discontinue in the absence of a
esponse. Restrict treatment periods to one
tients over sixty.
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l spondylitis.
cations: Children 14 years or less; senile pa-
ory or symptoms of G.I. inflammation or ul-
cluding severe, recurrent or persistent dys-
tory or presence of drug allergy; blood
renal, hepatic or cardiac dysfunction; hy-
; thyroid disease; systemic edema;
and salivary gland enlargement due to the
nyalgia rheumatica and temporal arteritis;
ceiving other potent chemotherapeutic
ong-term anticoagulant therapy.
Age, weight, dosage, duration of therapy, ex-
concomitant diseases, and concurrent potent
apy affect incidence of toxic reactions. Care-
ct and observe the individual patient, espe-
ging (forty years and over) who have
susceptibility to the toxicity of the drug. Use
ctive dosage. Weigh initially unpredictable
ainst potential risk of severe, even fatal, re-
e disease condition itself is unaltered by the
with caution in first trimester of pregnancy
ing mothers. Drug may appear in cord blood
milk. Serious, even fatal, blood dyscrasias,

including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 8615-9

What should a medication for sleep be expected to provide?

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholo dependence have not been reported recommended doses, use caution in ministering to addiction-prone indivi or those who might increase dosage

Precautions: In elderly and debilitate initial dosage should be limited to 15 to preclude oversedation, dizziness a or ataxia. If combined with other dru having hypnotic or CNS-depressant effects, consider potential additive ef Employ usual precautions in patient who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

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Dalmane (flurazepam HCl) has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane is in a class by itself. Not a narcotic, barbiturate or methaqualone, Dalmane is the only available benzodiazepine specifically indicated for insomnia.

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Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. In most instances when adverse reactions were reported they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity agent proved effective and relatively safe for relief of insomnia.

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depression or suicidal tendencies.
ic blood counts and liver and kid-
nction tests are advised during
ed therapy. Observe usual precau-
n presence of impaired renal or
c function.

e Reactions: Dizziness, drowsi-
ightheadedness, staggering, ataxia
ling have occurred, particularly
rly or debilitated patients. Severe
on, lethargy, disorientation and
probably indicative of drug intoler-
r overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indiff ent to the economic consequences their decisions." So stated a recen issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasin game, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated i crease in Blue Shield rates, Dr. Bla ingame's newsletter had this to say

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients . . .

"True, an MD's training is primarily scientific, but in the real wo of practice, all of his scientific deci sions have a price tag, or an econo impact. The economics of health ca beckon the practitioner's attention Concern for economics of medicine

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inter ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmacis made in the absence of clinical kno edge of the patient, could expose hi to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will nee expert knowledge of no more than 2

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d be an obligation of medical ice...

"Medical societies ought to con- continuing campaigns to point ne substantial savings that could alized thru deductible insurance protection for catastrophic ill- . At the very least, they should, in atients' interest, question the cs of any insurance organization raises health care costs by forc- olicyholders to buy insurance may not need or want and prob- won't ever use.

"Too many doctors are indiffer- o the economic consequences of decisions. Too many, for ex- le, habitually hospitalize patients ne convenience of the MD. It's ense to deny such habits exist...

"Doctors, thru their medical so- es, have unhesitatingly appealed eir patients for support in the against government interference the private practice of medicine. the public in the past has re- nded. It's time the American Med- Association and state and local ical societies paid off the debt by sive action to hold down the cost edical care."

of Drugs

Insurance rates and hospital ges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

0 drugs that he selects to treat the ority of conditions encountered in practice. Moreover, the physi- 's choice of a specific brand is ed on his knowledge of the pa- t's medical history and current dition, and his experiences with particular manufacturer's duct.

Some substitution proponents e argued that the dispensing of a scription is a simple two-party nsaction between the pharmacist the patient, and that a substitut- pharmacist may avoid even a nical breach of contract by simply ifying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted nout physician approval and who dertook a legal defense that seeks nake the patient responsible for pharmacist's actions.

luced Prescription Prices?

Substitution advocates are gesting to the consumer, and par- ularly the consumer activist, that luced prescription prices could ow legalization of substitution. have seen absolutely no evidence ustify this claim. To the contrary, perience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

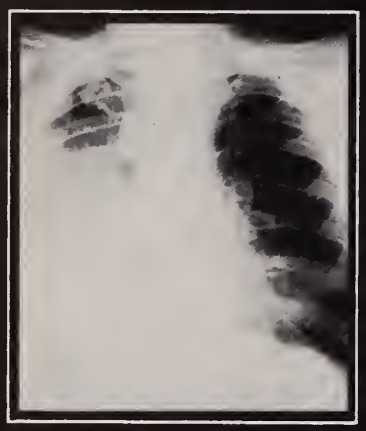
Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

HERE Pleural effusion



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Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

If You Can't Say Something Nice

MOST OF US REMEMBER the admonition so often repeated, that if you can't say something nice, don't say anything at all. Then came medical training. Caution bred of centuries of experience warns that any of us can error, that judgments of medical situations can differ, and that the errors of human reporting may lend dangerous shadows to specific events.

The errors of medical practice we came to accept, but never to like in ourselves or in others. Methods of monitoring for our own errors get built into our practice. This awareness aspect has on the whole been a healthy thing. It has prevented the over anxiety that goes with perfectionism, yet allowing the person to learn from error, and hence to grow more strong and competent.

The presence of third party payment organizations has forced a bit of scrutiny of our practice methods, as have the relatively mild systems of utilization review, surgical committees, and the like. It remains to be seen what the peer review will do to this well honed system of medical practice. Some of the suggestions that pour out nowadays seem utterly unaware of the sound learning principles established over centuries of medical experience and wisdom.

George Bernard Shaw, in his *Doctors Dilemma* and elsewhere, thought that all professions were but a conspiracy against the laity. But this cynical old gentleman should be alive today! Individuals have always existed who did not grasp the principles of medical PRACTICE, in the precise meaning of the word "practice."

Back in 1945 when I was in my second tour of military service, we had an adjutant of the base hospital who seriously believed and often expressed the firm opinion that errors in medicine should not be tolerated. He said that he had read the books and knew what the indications were for appendicitis. He said, not at all in jest, that if the tissue removed did not show definite pathology, then the doctor should be court-martialed, especially since it's so easy to know when to operate! Hopefully time has mellowed this bumptious young man. Unfortunately he has thousands of fellow spirits, some of whom may well be in the position to force physicians to make just that sort of judgment upon fellow physicians.

What Wisconsin doctors need is a **Malpractice Liability Carrier** that won't fade when trouble comes.

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A newly proposed peer review form contains several sheets of tests and measures for hospitalization of persons with specific diagnoses; e.g., coronary insufficiency, gallbladder. There are check lists to be marked by record clerks to see among other items if specific lab tests were done for that particular diagnosis. The purpose is to determine whether the doctor's management of a given case matches the "easily marked check list." If it does not, then that case folder should be forwarded for peer review. It's only a small concession that physicians are allowed to prepare the sheets. Human error looks so different on paper!

In my view, the issue seems to be far broader than the restrictive view of error and punishment or even beyond correction. It touches the very sensitive area of capacity to learn, without which the necessary humanism of medicine will be lost, maybe forever.

The other two points, varieties of judgment and perceptual distortions, will be discussed in the following months.—RH □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

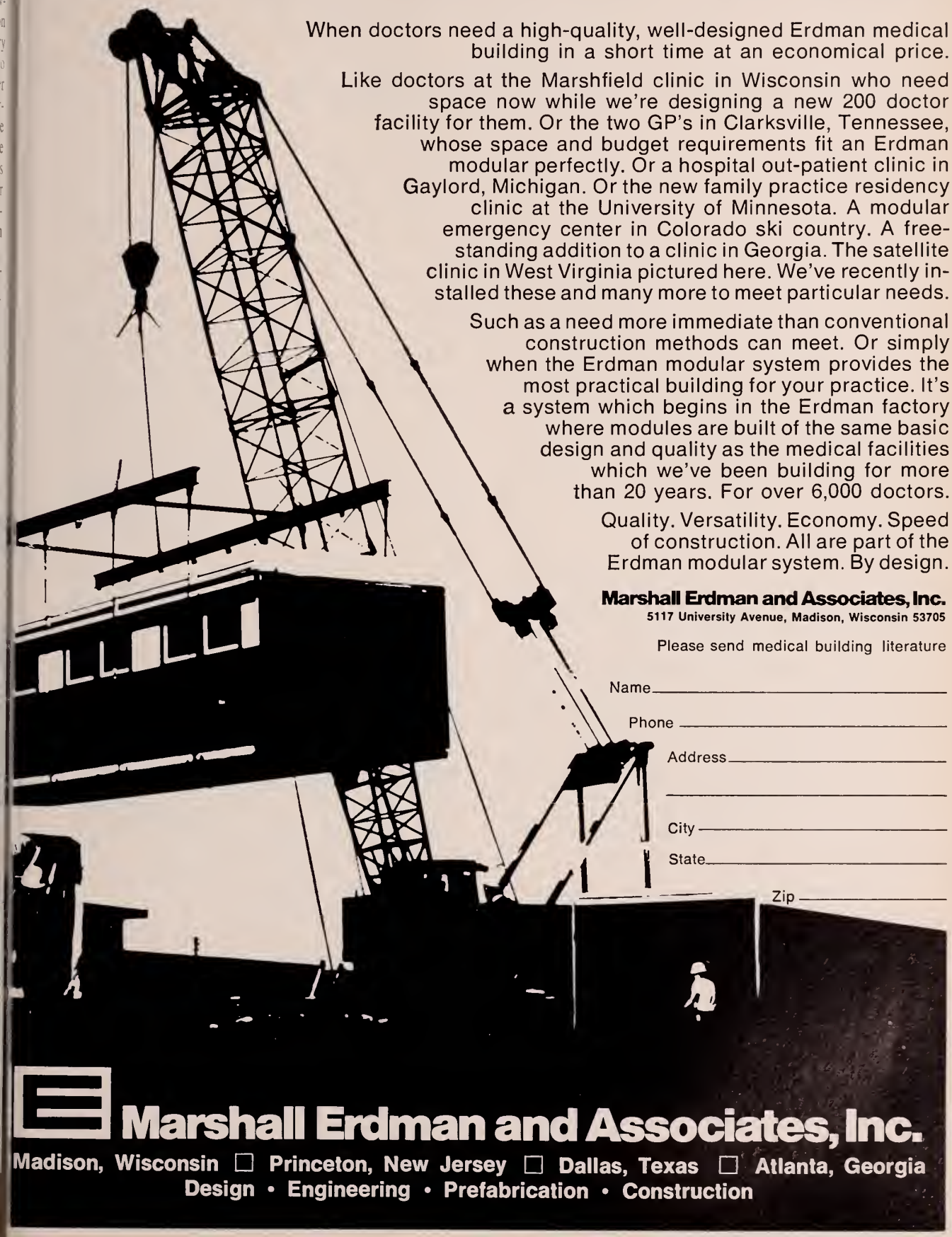
Support from City Mayor

TO: JOHN E. DETTMANN, MD: Congratulations on being elected to the prestigious position of President-elect of the State Medical Society of Wisconsin. This honor bestowed on you brings credit and recognition not only to you and your family but also to the City of Green Bay. I and the citizens of our community are indeed deeply grateful for this.

I understand that there are over four thousand physicians in Wisconsin and I can further appreciate the fact that there is much discussion these days regarding the many aspects of the practice of medicine as well as other providers of service aligned to medicine. One year hence, when you take office, your guidance and leadership in this awesome task will have my personal support and the best wishes of all of us in the City of Green Bay.

HARRIS G. BURGOYNE
Acting Mayor, Green Bay □

When are medical modules the best building method?



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HOW THE
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SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use, and to serve. To benefit fully from membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the fifth in a series of articles explaining State Medical Society organization and activities.

CES Foundation Supports Variety of Projects

THE ACTIVITIES OF THE Charitable, Educational and Scientific Foundation (CESF) encompass the wide-ranging commitments of State Medical Society members. The Foundation was created in 1955 by the House of Delegates as a natural outgrowth of an earlier trust for student loans. It has become involved in additional projects with the increase in volume of financial contributions. Today Foundation interests reflect some of the major concerns of medicine in Wisconsin.

Students in Health Careers

Financial assistance for health career students has been a traditional CESF concern since the Foundation's inception. Today CESF has loan funds to aid medical students as well as those preparing for careers in nursing, dentistry, pharmacy, and allied health fields. The loans are long-term, low-interest, and remain interest-free until after the student's graduation.

Loan funds have been set up by individuals as well as county medical societies and are administered by the Foundation according to the wishes of the donors. New loan funds are established at donors' requests.

For medical students, the Foundation also coordinates the Freshman Medical Student Summer Externship Program. This provides a ten-week externship with a family physician for students who have completed their freshman year of medical school.

The idea for the program came from the Family Medicine Club at the University of Wisconsin. The program was organized by the Wisconsin Academy of Family Physicians and quickly grew to involve students from the Medical College of Wisconsin.

The externship provides experience in the primary sector of medicine at an early stage in the student's medical career. It also provides a broad understanding of the role of the physician in the community. As a byproduct, it is hoped that a freshman externship will encourage the student to remain in the state to practice after completing his education.

Participating students receive fellowship grants from the Foundation. These have been made possible by contributions from physicians, hospitals, Wisconsin Physicians Service–Blue Shield, Surgical Care–Blue Shield, American Family Insurance, the Wisconsin Rural Rehabilitation Corporation, and Wyeth Laboratories.

Wisconsin Medical History

A continuing Foundation program focuses on the preservation and chronicling of Wisconsin's medical history and progress. A special organization of the Foundation for work in this area is the Academy of Medical History, a membership organization. The Academy publishes articles on Wisconsin medical history in the *Wisconsin Medical Journal* and acquires items of historical medical importance. It also places medical historic markers throughout the state. These pay tribute to outstanding Wisconsin physicians and institutions.

Museum of Medical Progress

One marker is at the site of Fort Crawford Military Hospital in Prairie du Chien. At this army outpost of Wisconsin's frontier days, Dr. William Beaumont laid the basis for our knowledge of digestion through his work on "the man with a hole in his stomach."

Today the hospital building where Dr. Beaumont did his work has been restored as the basis for the Foundation's Museum of Medical Progress and Stovall Hall of Health.

Museum exhibits trace developments in medicine through the frontier period and Civil War. In the Stovall Hall of Health are many displays on present day health care.

The Museum is a national registered landmark. Since it opened in 1960, it has attracted thousands of visitors from across the state and nation.

Recently, the Aesculapian Society was founded to provide a means by which physician's wives can actively contribute to the future development of the Museum of Medical Progress and its health–education programs. Dues are an annual $25 donation to the Museum.

Scientific Medicine

Foundation projects in teaching and research involve hundreds of MDs and allied health personnel annually.

Postgraduate teaching programs are made available to every county medical society through the Foundation's Speakers Service. This furnishes county society and councilor district meetings with reports on the latest in scientific knowledge from experts in Wisconsin's two medical centers, as well as from outstanding physicians located elsewhere in Wisconsin.

The Foundation's regional "in-depth" programs are day-long presentations on a particular medical problem. The programs combine discussions and lectures and attending physicians receive credit for their participation from the American Academy of Family Physicians.

Other scientific education projects of the Foundation have included conferences on the medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as maternal mortality institutes.

The Foundation is also available to assist in planning, administering, and funding investigations of a scientific or medical socio-economic nature. Past projects have included studies of the relationship between hearing loss and systemic disease (diabetes, coronary heart disease, and the like), the cardiac worker in industry, and the health care of the aged.

Charitable Assistance

Foundation assistance also extends to physicians, their families, and others who have experienced personal hardship. The Foundation provides an opportunity for professional persons to assist their colleagues in need. The number of those who have called for help in cases of severe disability or financial insecurity is not great, but when assistance is requested by a physician or his widow, the Foundation's response is vital. The Foundation's help in these cases reflects the medical profession's generosity in helping its own.

Policy and Administration

The Foundation is a non-profit, non-stock corporation under Wisconsin statutes. It is directed by a Board of Trustees composed of the Council and officers of the State Medical Society, one representative from each of the 54 component county societies, and up to 10 elected non-medical persons. This Board meets at least annually.

Periodically throughout the year, the Executive and other committees of the Board meet to handle the Foundation's routine affairs. The Executive Committee consists of the officers of the State Medical Society, the officers of the Foundation, and three elected trustees.

Through the Foundation's organization, it is integrated with the governing body of the State Medical Society and is closely linked with the county medical societies throughout Wisconsin. This arrangement assures a personal and realistic approach to Foundation activities.

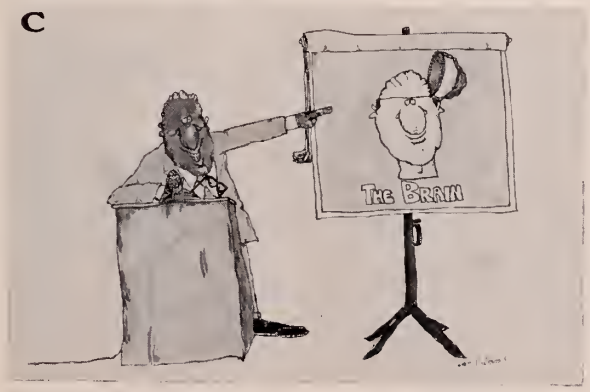
Opportunities for Giving

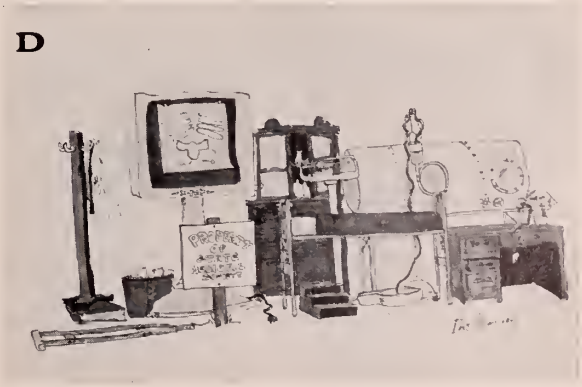
Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor.

All contributions to the Foundation are deductible for income tax purposes. □

These cartoons are part of an illustrated presentation on CES Foundation activities that has been presented to a number of county medical societies and auxiliaries. They show: (A) the wide range of talents on the board of trustees; (B) the freshman summer medical externship program; (C) scientific lectures available to county medical societies; and (D) gifts to the Foundation.





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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS MAY 1973

CERTAINLY, ONE OF THE answers to the medical profession's quest for greater benefit to the people it serves springs directly from efficient utilization of that most precious commodity, time. This need for efficiency implies the doctor should be freed from non-medical activity as much as possible and carries with it the stipulation that the desire of each patient for individual attention should be satisfied without compromise.

Your Medical Assistant—Asset or Liability

The initial impressions conveyed to the patient often color the doctor–patient relationship permanently. Your medical assistant should act as a buffer, and as a catalyst in the complicated synthesis of a satisfactory patient–doctor relationship.

The physician today runs a constant race against the clock. The ratio between number of doctors and population, the rise in standard of living, the increasing use of health insurance plans, and the increased desire of the public to have the best of medical care have all combined to create an unprecedented demand on the physician's time and energy. Not only must the energy the physician expends be considerable, it must be expended in the most efficient manner possible in the practice of medicine. It is here that a responsible, well-trained assistant can be a most valuable asset. She can assume a good deal of the more mundane and often purely business aspects of the practice.

A good medical assistant is honest and sincerely interested in people. A good medical assistant does not transgress the bounds of a respectful attitude. She assumes responsibilities but only if she is absolutely sure that they are within the realm of her ability and does not assume tasks which must be performed by the doctors only. She possesses a high degree of empathy and has higher than average ability to adapt herself to the moods of the doctor and the patients. She is constantly striving to improve herself in every pertinent way. For example, in becoming more familiar with medical terminology, in learning of new and more desirable methods of record keeping and accounting, and in developing a retentive memory. She holds inviolate the rule, "The patient's business is confidential".

Good medical assistants can mean the difference between a rewarding practice for you, the physician, and one that is less than satisfying. Whether she is escorting someone to the examining room, making an appointment over the telephone, comforting a worried patient, or simply standing by your side taking notes, she is creating an impression of your practice. She is the first person they see when they enter your office, the last when they leave, and probably the only one they speak with on the phone.

The climate of good will, concern and security she creates or fails to create can exhaust your practice or seriously threaten its success. How well she imbues patients with appreciation for the medical care received and her answers, for example, to questions on Medicare or other insurance problems are very important. The medical assistant is the symbol of the kind of service you provide.

As medical men you advocate the annual health check-up for evaluation of the status quo. As a medical assistant, I recommend an evaluation of your aide's good points or as the case may be the weaker ones, to make a determination as to which side of the ledger her activities place her—Asset or Liability.

The American Association of Medical Assistants, Inc.—Wisconsin Society is in a position to change the liabilities, if they exist, and to materially multiply the assets of your present medical assistants by offering educational opportunities. Our organization is the only one devoted to the continuing education of already employed medical assistants and will in October, 1973, offer a guided study program for those employees sincerely interested in self-improvement, either in skills or knowledge.

Doctor, you will be helping your medical assistant help you if you urge her to take an active part in the meetings and programs of the local medical assistants' chapters in Wisconsin. □

WPS®

report

for Wisconsin Physicians

Volume I Number 3 May 1973

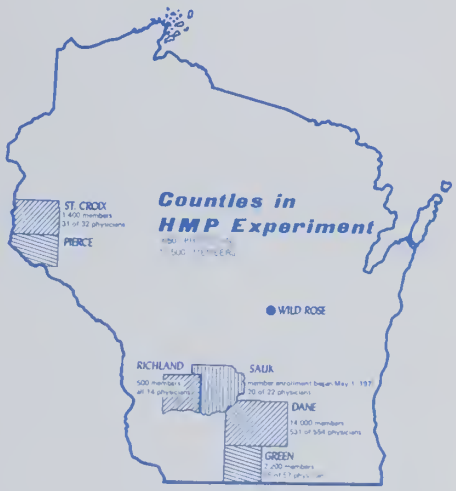
PREPAID HEALTH CARE IS LATEST WPS INNOVATION

Health Maintenance Plan is an improved health care financing system from WPS designed to:

1. Meet the specific challenges from those who contend that the health care delivery system must be reorganized; specifically, provide payment for primary care, curb excessive use of high cost settings and formalize a system to monitor office care.
2. Utilize currently available personnel and resources. While there may be some problems in geographical distribution of physicians, current personnel and facilities are presently caring for the patients and we contend the need for prohibitive costs of traumatic reorganization is not called for.
3. Preserve and protect the personal relationship between patients and their physicians.
4. Preserve and protect the relationship between physician and physician. It is a requirement that a system be open to all physicians who wish to participate, without undue advantage to any. Within this requirement is also the preservation and protection of the referral system throughout which physicians provide mutual support and quality patient care.
5. Assure continuation of a dominant role by physicians in the management and control of health care delivery.
6. Be acceptable to physicians, patients, employers and other premium payers as well as continue efficient administration.

Progress has been Made

Four (4) Health Maintenance Plans commenced during 1972 and a fifth in 1973. A high degree of physician support is apparent in each plan. Subscriber acceptance of HMP has been about 90%, with only about 10% electing to remain on regular insured benefits under the dual choice option.



WHY WPS IS IN HMP

WPS has been a fiscal and administrative arm of medicine in Wisconsin since 1946. During our first 20 years we functioned as a Blue Shield Plan providing insurance benefits for health care. In this role, WPS is an effective competitor in the health insurance industry and more importantly a leader in enlightened benefit design. In the mid-60's, the administrative role of WPS became more prominent with the addition of the Medicaid and Medicare Programs. In this, we try to represent both health care providers and the government in a fair, efficient and understanding fashion. In 1970, the idea of alternate forms of health care delivery and financing emerged as a possible answer to some of the nation's health care problems. This idea has achieved visibility and considerable interest as "Health Maintenance Organizations." WPS recognizes that developments in this field could profoundly influence the future shape of the health care system. Considering our commitments to quality health care and our experience in innovative programs, the WPS involvement in health maintenance experiments is natural and enviable. Our experiments, known as *Health Maintenance Plans*, grew out of an attempt to combine the best features of the current delivery system with the best features of prepaid group practice, minimizing the disadvantages of each.

Please tear out and file with Report series in three-ring binder

and their Medical Assistants

Here's How "Peer Review" May Affect *You*

In our last Report, we briefly introduced you to the concept of peer review of physicians' patterns of medical practice. While much of the development of this program is still conceptual in nature, there are certain specific areas that we will be emphasizing on an immediate basis.

X-ray and laboratory services in the physician's office or clinic will be scrutinized closely for a relationship between the tests performed and the given diagnosis. For example: If the only diagnosis listed is acute respiratory infection, we would not want to provide payment for a knee x-ray. You might ask: "Why doesn't WPS pay the knee x-ray, as this certainly would not be part of a routine physical examination?" While this may be true in some instances, we are not in a position to automatically make this assumption on all unrelated x-ray or laboratory services. If there is a medical reason, it should be stated also.

Secondly, we will continue **claims review** to determine when physician services primarily involve a routine physical examination. Without going into the pros and cons of preventive medicine, it is not the intent of WPS to provide benefits for annual examinations under regular health insurance. Therefore, if we receive a claim and there is a general diagnosis given such as anemia, hypertension (age 55 or older), obesity, post-menopausal syndrome, varicose veins, hemorrhoids, etc., it is very possible that the claim will be denied as the services billed appear to be a typical package physical examination. Birthday diagnosis, i.e., general conditions that appear with age, on the report does not automatically qualify all services for payment.

Clearly it is not our intent to suddenly start deleting x-ray and laboratory charges. Questions of medical necessity will be reviewed by qualified individuals and handled judiciously. We at WPS do not want to increase your paper work, but we do want to ask you to be as careful as possible when submitting claim reports for multiple office x-ray and laboratory charges. And we want to provide payment for those charges which are properly covered by our policies. Our success to a great degree is influenced by the completeness of your reports.

NEW SUPPLY JUST IN . . . ALCOHOLIC AMERICAN AND DRUG ABUSE

Alcoholic American. All statistics on the alcoholic are unfavorable. When one considers that the abuse of alcohol takes thousands of lives each year, and costs the American economy up to $8.0 billion in inefficiency, time lost from work, etc., it then becomes apparent just how close the problem is coming to everyone.

Drug Abuse: The Chemical Cop-Out. "In the final analysis, playing games with the truth has historically

been demonstrated to be a mistake." With these words, Dr. Robert E. Peterson of the National Institute of Mental Health expressed the need for honest enlightenment in dealing with the problem of drug abuse. This booklet provides basic information on dangerous drugs and narcotics. It also takes a look at the users and examines some of the factors which may be contributing to increased drug use.

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Standards and Guidelines

for a

Radiotherapy Network in Wisconsin

PAUL C. NUTT, MS and PAUL C. TRACY, MD, Madison, Wisconsin

IN HEALTH CARE there are at least two types of standards: those related to the practice of medicine and those associated with health services planning. Medical practice standards are used in processes for peer review and quality assurance like those of the Professional Standards Review Organizations. Standards of this type permit a comparison of observed practice to recommended practice to identify significant deviations.

In contrast, standards of the latter type concern the resources needed to provide health services. This article concerns standards associated with planning and evaluating the need for health services, focused on the resources needed to provide radiotherapy services.

Many planning agencies and hospitals have requested the Wisconsin Regional Medical Program (WRMP) to develop standards for radiotherapy units. To meet these requests, a committee of expert radiotherapists was identified and, with WRMP staff support, assigned the task of specifying standards and guidelines. The criteria for membership on the committee were: expertise in radiotherapy, geographic balance, and representation of key provider groups. Using these criteria, radiotherapists were selected by the State Medical Society of Wisconsin, the Wisconsin Radiological Society, and the Wisconsin Radiotherapy Society. Members of the "Radiotherapy Committee" were: William Caldwell, MD, Madison; Stephen Dudiak, MD, Madison; Robert W. Edland, MD, La Crosse; Frank Ellis, MD, Milwaukee; Robert H. Greenlaw, MD, Marshfield; Anthony Grueninger, MD, Milwaukee; Stanton Marks, MD, Milwaukee; John F. Mokrohisky, MD, Green Bay; John G. Parrish, MD, Fond du Lac.

All agreed to serve and participated in each step of the standards setting process. The committee set out to establish "workable" standards for resource categories such as personnel, equipment, and the like needed to operate an acceptably efficient and effective radiotherapy unit. As each member of the committee practices radiotherapy in the state, they are aware of local conditions and factors which affect radiotherapy practice and whether these factors should affect radiotherapy standards and guidelines for a radiotherapy network in Wisconsin.

Representatives of CHPASEW and HPC, areawide health planning agencies, were also represented at various stages of the process to insure that standards were sufficiently precise to meet their "review and comment" and planning needs. Many important issues in radiotherapy were identified through the participation of these agencies.

It is the conviction of WRMP that standards are essential and that these standards must be developed by expert physicians practicing in Wisconsin. WRMP's process of standards development permits an optimum understanding of radiotherapy and the Wisconsin health setting to be reflected in the standards. Both the public and the health professions benefit from explicit standards developed by those knowledgeable of medical practice. As standards are explicit, the evaluations of regulatory agencies can be better understood and critiqued by both health providers and health consumers.

Methods Used to Set Standards

Our experience suggests that the process of setting standards, outlined below, increases the specificity of the standards selected and permits key Wisconsin health care providers to interpret national standards in the Wisconsin health situation. Such a

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Mr. Nutt is Planning Director for the Wisconsin Regional Medical Program, Inc.; Doctor Tracy is the Associate Coordinator for Program Development and Evaluation for WRMP.

Publication support by the Wisconsin Regional Medical Program, Inc. is gratefully acknowledged.

Reprint requests to: WRMP, 5721 Odana Rd., Madison, Wis. 53719.

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process permits adaptation to local conditions—increasing the likelihood that the standards selected will be adopted and implemented.

The first step in the procedure is the development of a survey instrument. The survey is based on standards (for example, the amount of training required for physicists) proposed for resources needed to conduct radiotherapy. Other agencies through volunteer committees of expert radiotherapists, such as "The RMPS Committee on Radiotherapy Studies," have recommended radiotherapy standards. The recommendations made for each standard, mentioned by these sources, were elaborated in the survey. Where disagreement among standards was noted, the recommendation of each agency was described.

Standards proposed by a variety of sanctioning agencies[1] were reviewed by the staff to arrive at a synthesis of "resource categories" (such as personnel, radiation sources, and the like) necessary to operate a radiotherapy unit and to determine crucial matters of unit justification, such as patient volume. These recommended categories were analyzed and a synthesis proposed that seemed to represent the needs of radiotherapy. Using these categories, a sample survey was prepared. The survey listed "resource categories" (i.e. personnel) and subcategories (i.e. manpower categories such as radiotherapists) as well as key aspects of each category or subcategory such as capacity (i.e. volume of patients needed to justify a radiotherapist), qualifications (i.e. need for board certification), and other factors identified in these reports. Each resource category had a "scale" which provided a range of choice. The survey was designed to be easily completed by checking an option or by marking a scale. For example, the resource category "supporting clinical facilities" and subcategory "Treatment Planning Simulator" was presented in the survey as follows:

1. Is a Treatment Planning Simulator justified:
   ____Yes ____No
2. Specify the minimum number of patients per year needed to justify a treatment planning simulator

   |———|———|———|———|———| Patients
   0 100 200 300 400 500
   ↑
   (1,6)
3. Access to treatment planning capability required
   ____ in center (1)(6)
   ____ in center and available to affiliated radiotherapy centers
   ____ on consulting basis
   ____ other

The numbers in parentheses in the example above provided a convenient summary of the recommendations made by other radiotherapy reports. Note that the radiotherapy committee specifies standards concerning justification, capacity, and relationship of each resource to the unit. Hence, the committee has complete freedom to select an appropriate level for each standard.

All resources needed to operate a radiotherapy unit and a synthesis of recommendations were gleaned from previous radiotherapy recommendations and put in the survey using a format like the example above. An out-of-state expert in Radiotherapy aided WRMP by interpreting existing standards and reviewing the survey.

The next step in the process had each member of the committee complete the survey prior to a face-to-face meeting. Initial responses of the committee were summarized and used as a focus for discussion in the meeting. The typical (or median) committee response was defined for each standard as initial committee consensus and served as a stimulus for discussion in the meeting.* This process had the following benefits: aided the committee to redefine concepts; encouraged members to challenge the appropriateness of the initial standards without criticizing a colleague or associate; served as a vehicle to generate information on why a particular standard was appropriate or inappropriate; provided information concerning the reasons for choosing a particular level for a given standard. After discussion, a new vote was taken and the consensus view, from this final vote, was adopted. The radiotherapy standards described in this report were derived from this process.

These radiotherapy standards should not be regarded as optimal or ideal. Increased sophistication in clinical practice, as well as the phasing out of certain radiotherapy units, will alter the desirable characteristics of a radiotherapy network in the future. New procedures derived from medical research will also render all standards, either normative or workable, obsolete. Hence, periodic revision of standards of any type is needed.

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* This process of setting standards was adopted because research findings related to obtaining "subjective estimates," using the "talk-estimate-talk" sequence, and the nominal group meeting format, were found to be superior to other options.

Standards for Development of Radiotherapy Units in Wisconsin

I. The Radiotherapy Network: The Purpose and Relationship of Network Components

Three types of radiotherapy components (termed units) were identified as appropriate by the Radiotherapy Advisory Committee. These units are defined below:

NAME OF UNIT	TYPE	PRIMARY FUNCTION	MISSIONS
"Radiotherapy Center"	I	Education and training	.Patient care .Education and training .Basic and clinical research
"Clinical Radiotherapy Center"	II	Patient Care	.Patient care .Clinical research .Training affiliated with Type I or independent
"Affiliated Radiotherapy Facility"	III	Patient Care	.Patient care, in affiliation with either Type I or Type II center

Type I and Type II units represent the centers evolving toward optimum utilization of resources and using optimum radiotherapy skills and technology. Generally, Type III centers are in the state of flux—*either growing or declining, but not static.*

The Type III center should be rapidly approaching a Type II center (by meeting the standards outlined for Type II units) or should be making arrangements to phase out its services. A Type III center must be related* to a Type I or Type II unit for consultation referral of patients, and backup services. It is expected that such a center would not be able to treat the total spectrum of cancer as some equipment and personnel cannot be justified with current patient loads. Moreover, part-time work in radiotherapy is necessary due to the comparatively small volume of patient care. In summary, the scope of patient care in a Level III unit is limited; the unit must be in the process of differentiation, growing or phasing out; and the unit must be affiliated with a Type I or Type II radiotherapy unit.

A Type II radiotherapy unit may be related to a Type I center in the conduct of both training and research programs. In contrast to the Type III unit, the Type II radiotherapy unit can be fully equipped and able to handle the entire spectrum of patient care problems for which radiotherapy is a useful modality.

The Type I radiotherapy unit often represents a University Clinical Department. Hence, the mission of this department, in addition to patient care, is education and training, basic and clinical research. The Type I unit is fully equipped to deal with the entire range of patient problems. Full utilization of these resources is limited by the multiple missions of the unit, education, and research. Hence, all resources may not be fully utilized in a Type I unit.

The differentiation of radiotherapy units into three types of centers for patient care does not imply or encourage different levels of care. Care undertaken in any unit for a given patient must represent optimum care for that patient. If the needed resources are lacking in a given unit, a referral to another unit is required so optimum care is obtained. Provisions to share resources among Type I and Type II units should be aggressively explored—particularly in urban areas.

Complete standards and guidelines for radiotherapy units are specified in the following section of the report, indicating personnel, equipment, supporting facilities, patient load, and other resource needs of each radiotherapy unit. Table 1 applies these standards to hypothetical units operating at maximum and minimum recommended case loads. This indicates the range of resources for each unit. The equipment needs, team size, and the like shown in Table 1 were obtained by combining patient volume (i.e. 600 new cases) with capacity requirements (i.e. 300 new cases/unit of a resource) to get the recommendation (600 new cases x 1/300 new cases/unit or two resource units). Hence by forecasting the number of new patients in any geographic area, plans can be drawn that describe a deployment of units to meet the radiotherapy needs of those residing in that area. The last section of the report describes regional considerations and a process for the implementation of the standards.

II. Standards for Operational Characteristics of Radiotherapy Units

A. Patient Load

TYPE I: A minimum of 600 new cancer patients per year to receive radiotherapy treatment is required to insure maintenance of care quality and care economics. Beyond 1500 new patients per year, a new center should be planned.

TYPE II: A minimum of 300 new cancer patients per year to receive radiotherapy treatment is required to insure maintenance of care quality and care economics. Beyond 1000 new patients per year a new center should be planned.

TYPE III: Units below 100 new cancer patients per year to receive radiotherapy cannot insure maintenance of care quality and care economics. When the center approaches 300 new patients per year, formal plans should be well underway for the transition of this unit to Type II.

B. Personnel Requirements

1. RADIOTHERAPIST

TYPE I: *Qualifications:* All radiotherapists should be Board certified in radiation therapy, or its equivalent, and practicing full-time radiation therapy. *Capacity:* 200 new radiotherapy patients per year could be managed by each radiotherapist: *Time Commitment:* Exclusive of teaching and research, radiotherapists should be spending full time in patient-care activities.

TYPE II: *Qualifications:* Same as Type I. *Capacity:* 300 new radiotherapy patients per year could be managed by each radiotherapist. *Time Commitment:* Full time should be spent on radiation oncology activities exclusive of clinical research activities and associated educational responsibilities.

TYPE III: *Qualifications:* Same as Type I and Type II or should be Board certified in radiology

* "Related to" and "affiliation agreements" mean a mutually agreeable relationship among units to obtain patient-care consultation, treatment planning, physics support, and other services through periodic consultation paid for by any mutually acceptable mechanism.

TABLE I—*Illustration of radiotherapy resources needed in maximum and minimal size radiotherapy units*

Type of Radiotherapy Unit	I. Patient Load: New Radiotherapy Cases Per year		II. Personnel Requirements: Patient Care Team		Treatment Planning Team	
	Minimum	Maximum	Minimum size unit	Maximum size unit	Minimum size unit	Maximum size unit
"Radiotherapy Center" TYPE I	600	1,500	3 Radiotherapists 2 Physicists 4 Radiological Technicians 1-1/2 Nurses* 4 Residents and Training Fellows	7-1/2 Radiotherapists 5 Physicists 10 Radiological Technicians 3-3/4 Nurses 10 Residents and Training Fellows	4 from personnel categories (dosimetrists, mould room technicians, simulation technicians, electronic technicians, machinists)	10 from personnel categories (dosimetrists, mould room technicians simulation technicians electronic technicians machinists)
"Clinical Radiotherapy Center" TYPE II	300	1,000	1 Radiotherapist 3/4 Physicist 2 Radiological Technician 3/4 Nurse 2 Residents and Training Fellows	3-1/3 Radiotherapists 2-1/2 Physicists 6-2/3 Radiological Technicians 2-1/2 Nurses 6-2/3 Residents and Training Fellows	1 from personnel categories (dosimetrists, mould room technician, simulation technician, electronic technician, machinist)	5-2/3 from personnel categories (dosimetrists, mould room technicians simulation technicians electronic technicians machinists)
"Affiliated Radiotherapy Facility" TYPE III	100	300 transition to Type II complete at this volume of patients	1/3 Radiotherapist 1 Radiological Technician 1/4 Nurse *Full-time equivalent	Transition to Type II unit has been completed	None: Consultation with Type I or Type II unit	Transition to Type II unit has been completed

or its equivalent. *Capacity:* Radiotherapists with fewer than 300 new patients per year should consider ways to phase out or expand their patient load. *Time Commitment:* Part-time radiotherapists are permissible in this category if their units are in the process of satisfying the standards for Type II units or phasing out.

2. PHYSICISTS

TYPE I: *Qualifications:* Master's degree in physics with experience in clinical radiotherapy physics satisfactory to the radiotherapist or certified by the American Board of Radiology or its equivalent. *Capacity:* Approximately 300 new radiotherapy patients are needed to justify one physicist. *Consultation:* Additional physics support may be needed to consult with other radiotherapy units.

TYPE II: *Qualifications:* Same as Type I. *Capacity:* An annual volume of 400 new radiotherapy patients is needed to justify one physicist. At least one full-time physicist is needed in each unit who, initially, can handle dosimetry and mould room work. As patient-care load increases, a dosimetrist should be added. *Consultation:* Same as in Type I.

TYPE III: While physics support in the unit is required, it should be provided by an "affiliation agreement" with either Type I or Type II radiotherapy units.

3. RADIOBIOLOGIST

TYPE I: Recommended.
TYPE II: May be justified.
TYPE III: Not justifiable.

4. RESIDENTS AND TRAINING FELLOWS

TYPE I: An annual volume of 150 new radiotherapy patients is needed per resident or per trainee.

TYPE II: Residents may be rotated from Type I radiotherapy unit or may be primarily based. Consequently a patient load comparable to a Type I unit is needed for each fellow or resident.

TYPE III: No residents or training fellows will receive clinical training in this setting.

5. RADIOTHERAPY TECHNICIANS

TYPES I, II, and III: *Qualifications:* Registration by American Registry of Radiological Technologists or its equivalent, as specified by the radiotherapist. *Capacity:* Two technicians should be made available for each fully utilized megavoltage radiation source.

6. NURSES

TYPES I, II, and III: *Qualifications:* Nursing care is essential but can be performed by a RN, LPN, or properly trained technician. *Capacity:* 400 new radiotherapy patients per year can be managed by each nurse or equivalent.

7. OTHER MEMBERS OF THE TREATMENT PLANNING TEAM

a. *Personnel categories*

Dosimetrists, mould room technicians, simulation technologists, machinists, and electronic technicians.

b. *Standards*

TYPES I and II: *Qualifications:* Skills are usually obtained by on-the-job training and by practical experience in similar jobs. Dosimetrists and simulation technologists should have some technical training and preparation if they are to be responsible members of the Treatment Planning Team. *Capacity:* The balance among personnel categories depends on orientation of the center. Each member of the Team should be able to perform a variety of functions. For small centers a physicist often is responsible for some

TABLE 1—*(continued)*

pe of Ra- otherapy it	III. Radiation Sources		IV. Bed Requirements	
	Minimal Size Unit	Maximal Size Unit	Minimum Size	Maximum Size
YPE 1	.One 1-4 mev range radiation source .One 6-25 mev range radiation source (with electron beam) (Note: this equipment has the capacity of handling 700 new patients per year--hence in a minimal size Type I unit 85% utilization is optimal) .One 45-450 kv radiation source .Radium sources on hand	.Three 1-4 mev range radiation source .One 6-25 mev range radiation source (with electron beam) (Note: various other combinations of equipment can also be justified. Choice depends on research emphasis, patient population, etc.) .One 45-450 kv radiation source .Radium sources on hand	.9 beds/center for acute care .17-33 beds available for minimal care .5 beds/center for clinical research	.22 beds/center for acute care .36-72 beds available for minimal care .5 beds/center for research
YPE II	.One 1-4 mev range radiation source (Note: other equipment is not justified until patient volume has increased) .One 45-450 kv radiation source .Radium sources on hand	.Two 1-4 mev range radiation source .One 6-25 mev range radiation source (with electron beam) (Note: this combination of equipment is 83% utilized. As a practical matter, 100% utilization, in radiotherapy units, will not always be feasible.) .One 45-450 kv radiation source .Radium sources on hand	.4.5 beds/center for acute care .8-16 beds available for minimal care .No research beds	.15 beds/center for acute care .23-56 beds available for minimal care .No research beds
PE III	.One 1-4 mev range radiation source (Note: patient load is too small to justify anything but the most versatile radiation source) .One 45-450 kv radiation source .No radium	Transition to Type II unit must be completed for this level of patients	.No acute or research beds .Provision for 6-12 minimum care beds within commuting distance of unit	Transition to Type II unit must be complete for this level of patients

treatment planning tasks (i.e. dosimetry, mould room preparation, and the like). Hence for minimal size units, no more than one person is needed in Type II units and a team size of 4 is suggested for minimal size Type I units. For each additional 150 patients above minimal unit size, an additional team member can be added.

8. Other Personnel

Personnel categories such as statistician, computer programmer, record clerk, photographer, are often needed. Small units should combine these functions (i.e. combining clerical functions) or contract for these services with larger units (i.e. statistical analysis or computer programs) or with organizations in the immediate area (i.e. photography).

C. Radiation Sources

Choice among mev range radiation sources is dependent upon the orientation of the radiotherapists. Combinations of sources are often used. For example, when patient loads are greater than 300, a 1–4 mev range or a 6–25 mev range can be obtained as a second radiation source.

1. Isocentric Cobalt or Linear Accelerator (in 1–4 mev range)

Types I and II: A volume of 300 new radiotherapy patients per year is required to fully utilize this type of mev range equipment.

Type III: A volume of 100 new radiotherapy patients per year is required to justify this type of mev range equipment. A reasonable prospect to achieve a patient load of 300 new radiotherapy patients per year must be provided.

2. Linear Accelerator with Electron Beam or Betatron (in 6–35 mev range)

Types I and II: A volume of 300 new radiotherapy patients per year is required to utilize fully this type of mev range equipment.

Type III: Equipment is not justified.

3. Superficial X-Ray (45–120 kv) or Kilovoltage Equipment (up to 400 kv)

Types I, II, and III: At least one, but no more than one, kilovoltage unit should be available at each center.

4. Radium and Radium Equivalent Cesium (Isotope Sources)

Types I and II: Is recommended that 300–500 mg should be on hand. The radiotherapist should retain responsibility for all interstitial or intracavitary placements.

Type III: Intracavitary placements only, radium sources should be rented.

D. Supporting Clinical Facilities

1. Treatment Planning Simulator (TPS)

Types I and II: Treatment planning simulator is justified for both and requires a volume of about 300 new radiotherapy patients per year. When a third radiation source is added, a second TPS may be justified.

Type III: An affiliation agreement to obtain treatment planning assistance from Type I or Type II centers is required.

2. Digital Computer

Types I and II: At new patient volumes of more than 300, the support of a digital computer is needed. Computational capabilities can be located in the unit or by sharing.

Type III: Not justified.

3. Tumor Localization

Types I and II: Equipment with tumor location capability, done by ultra sound, by x-ray, or

by other methods is open to justification.

TYPE III: Not justifiable.

4. OTHER SUPPORT FACILITIES AND SERVICES

a. *Minor surgical suite for interstitial and intracavitary implants*

For Type I and Type II units, minor surgical suites should be located in the facility housing the radiotherapy unit. The load in a Type III center would not justify a minor surgical suite. One hundred and fifty implants or intracavitary placements per year are required to justify a minor surgical suite.

b. *Dressing rooms and ready waiting rooms*

Two rooms or cubicles, one of each type, are needed for each treatment room. These rooms should preserve the dignity of patients.

c. *Follow-up facilities*

For Type I and Type II radiotherapy units, follow-up facilities can be shared with other oncology services or may be an integral part of radiotherapy facility. For Type III units, sharing or cooperative arrangements with local hospitals are appropriate.

d. *Provisions for registry*

A capability for the storage and retrieval of clinical data, depicting treatment outcomes, should be operated and controlled by the Type I and the Type II unit for their own uses and operated as a service to Type III units. The Type III unit would be served by one of the larger units. Computer hardware and software would be located in the center for supporting Type I and Type II radiotherapy units. Provisions to share services among Types I and II units must be aggressively explored—particularly in urban areas.

Cancer registries are required for each radiotherapy unit. High volume Type I and Type II units typically operate their own programs and provide data processes and software services to Type III centers.

e. *Tumor Boards*

For Type I and Type II center units, multidisciplinary conferences describing or recommending patient care are needed. Radiotherapists, pathologists, chemotherapists, surgeons, and hematologists should be represented. In addition, physicists and statisticians are needed to support the work of tumor boards and some contact with referring physician is needed.

f. *Radiological Physics Laboratory*

Both Type I and Type II units require labs located in the center and Type III units do not.

g. *Machine Electronics Shop*

For Type I and Type II units, machine and electronics shops must be located within the center or in the community. In contrast, the Type III center requires only the services of a small multi-purpose shop.

h. *Beds*

One and a half acute-care beds are needed for an annual patient load of 100 new radiotherapy patients. In contrast, between 2.5 and 5.5 minimal-care beds are needed for each 100 new radiotherapy patients per year, depending on local bed availability. Clinical research beds are justified only in a Type I or Type II center, at about 5 beds per center.

i. *Research Programs*

Type I center conducts both basic and clinical research. Type II centers can conduct clinical research. Collaborative research and studies are encouraged.

E. Training Programs

TYPE I: Both graduate and postgraduate training programs for radiotherapists, radiophysicists, dosimetrists, radiotherapy technicians, and radiobiologists should be provided.

TYPE II: Residents and training fellows as well as masters physicist candidates may be rotated from Type I to Type II radiotherapy units to receive clinical experience.

TYPE III: No graduate or postgraduate training should be provided in this setting.

F. Referral Mechanisms

TYPES I, II, and III: Physicians referring patients for radiotherapy should be appraised of the intent of therapy, length of therapy, and stage of disease by the radiotherapist. The referring physician should also receive periodic status reports concerning the patient during treatment. A final report describing further care recommendations should be submitted by the radiotherapist to the referring physician.

Ideally, the total cancer treatment plan should be devised by all cancer disciplines (radiotherapy, chemotherapy, surgery, hematology) as well as the referring physician. "Group follow-up" is also useful with the primary physician and the radiotherapist seeing patients alternately or jointly when feasible. Both the referring physician and the radiotherapist should follow patients through a cancer registry, to insure continuity of care and follow-up.

G. Distribution of Facilities

The distribution of radiotherapy units can be estimated by specifying the capacity of units and the maximum permissible commuting time for patients (and by estimating annual patient load). Patient-care access needs were suggested to be:

TYPE I: Not relevant as primary goal broader than patient care.

TYPE II: Within two-hour one-way commuting time for periodic therapy.

TYPE III: Not relevant, as unit in process of phasing out or becoming a Type II unit.

Regional Considerations

The guidelines developed in this section detail some of the steps needed to improve the process of radiotherapy center planning and development in Wisconsin. To insure that a high degree of professional expertise is involved in revising and interpreting these standards, WRMP recommends continued support for the Radiotherapy Committee. Health planning agencies who have the responsibility of applying these standards to evaluate the need for proposed enlargements of units or new radiotherapy units, could draw on the committee for expert counsel. For those proposing to expand or question the advisability of providing these services, the committee can interpret their radiotherapy

standards in terms of the particular circumstances and needs that justify changing the current profile of radiotherapy services. The committee can also provide evaluations of existing and proposed radiotherapy units with the assistance of appropriate agency staff.

The activities recommended for any regulatory body(s) involved in monitoring or evaluating the development of radiotherapy units include:

A. Forecasting the need for radiotherapy services.

B. Determining whether elements in the evolving network of services should be enlarged or phased out, as indicated by radiotherapy needs.

C. Insuring that new radiotherapy units adhere to orderly development of appropriate services as specified by standards above.

D. Attempting to restrict the addition of new radiotherapy units until existing units have reached optimum caseloads.

E. Developing review mechanisms that insure: equipment will not be purchased until an adequately trained radiotherapy treatment team is available; appropriate "affiliation agreements" have been developed; treatment is not initiated until a peer review or quality assurance program is planned for the unit; and agreements for regionwide exchanges of information concerning the outcome of radiotherapy treatment, including information needed by peer review mechanisms in centers and among centers, can be secured.

F. Investigating the impact of combining mould room, treatment planning facilities, and similar specialized resources for several radiotherapy units to determine whether such an arrangement is effective and efficient in a network of radiotherapy services. In urban areas provisions to share resources among Type I and Type II units must be explored.

G. Aiding appropriate health planning agencies in development of a total cancer program which includes: early discovery and diagnosis, prompt referral to most appropriate treatment sources, follow-up services, parallel development of radiotherapy with other cancer diagnostic and treatment facilities and services.

Estimating Needs for Radiotherapy

To apply standards, a forecast of number of new patients per year who need the services of a radiotherapist is needed (Table 1). Given this information, and knowing the range of permissible volume for each center, estimates of the total number of centers needed in a state can be made. By projecting these needs, crude estimates of the growth of radiotherapy units, based on patient-care needs, are also possible.

To further refine these estimates, the concept of patient travel time must be added. The number of units must meet the joint criteria of capacity and travel time (i.e. meet both professional and consumer requirements).*

There are a number of acceptable ways to obtain necessary estimates of number of new patients per year. The method selected depends upon the intended use of the "radiotherapy plan" and on the accuracy of other estimates. For example, there is no point of obtaining highly accurate estimates of patient volumes when standards are comparatively imprecise. Choice among these methods depends upon overall reliability of the data being dealt with and whether the plan will be used to make decisions or to generate recommendations.

Methods which are useful in obtaining forecasts of radiotherapy patient volumes include:

1. Extrapolation of historical data

WRMP has planned a joint program with the State Division of Health to survey Wisconsin hospitals to determine profiles of discharge diagnoses. Assuming that all those with cancer will be hospitalized at some point, discharge diagnoses provide a reasonable estimate of total cancer needs at any point in time. An expert radiotherapist would be asked to characterize each cancer diagnosis (using, for example, sites such as cancer of the cervix, Hodgkin's disease, and the like) and determine the extent radiotherapy is a useful treatment for the typical patient with this diagnosis. Extracting all cancer diagnoses that need radiotherapy from the survey gives an estimate of the total new patients per year needing radiotherapy treatment. This number can be extrapolated into the future using expected population growth as the extrapolation variable (or denominator).

2. Subjective estimates

Subjective estimates could be used to determine volumes of patients using a process similar to that used to obtain standards. Expert radiotherapists can be quizzed to determine the number in each diagnostic category in the state, or in certain regions of the state, that could benefit from radiotherapy. For example, a representa-

* The travel time recommended in the standards section above represents the perception of professionals. Consumers should be involved in final specification of travel time but the permissible travel time suggestive above may represent an initial planning figure.

tive of Clinic A could provide estimates of total number of cancer patients seen in the "immediate area" of the clinic as well as the number of those patients seen with cancer of the lung, cervix, and the like and the proportion of these cancers that would benefit from radiotherapy. A simple verbal contact with major sources of cancer treatment can provide crude estimates of the profile of cancer treatment in the state. This volume can be extrapolated in the same manner as described above.

3. Prospective surveys

Surveys could be designed to record cancer treatments as the treatment is provided. A sample (or all) radiotherapists in the state could classify their patients according to diagnosis, site of disease, stage of disease, type of treatment, and the like over a certain length of time. These data could be extrapolated as described above to form an estimate of radiotherapy patient volumes. This method is probably more accurate and more expensive than the previous two as it is pro-active and because it is dedicated to collecting just "radiotherapy data."

Implications and Conclusions

This report has described standards for radiotherapy units which have been developed by expert Wisconsin radiotherapists. It is hoped that this information will be useful to agencies interested in estimating the future needs for radiotherapy services or in planning these services.

In any particular subregion of the state, local conditions may require adaptation of these standards. For example, in urban areas, broad sharing of resources among radiotherapy units may have important cost and effectiveness implications. However, the standards stated in this report may not reflect the extent sharing can and should take place.

In contrast, rural areas have problems of travel time and comparatively low volume. Ways to increase patient load in some sites and phase out other sites as well as locating services so patients have reasonable travel times are important issues. Here again the standards may not reflect local adaptations that may be needed.

It is clear, however, that the historical growth of radiotherapy units in the State of Wisconsin cannot be justified.[2] Extrapolating national incidence rates, there are 14,600 new cancer patients per year in Wisconsin. Of this total, "between 50% and 70% will require curative and palliative radiotherapy treatment."[3] Hence, there are between 7,300 and 10,220 new radiotherapy patients in Wisconsin each year. If existing units were operating with *minimal* adherence to the standards cited, a capacity of 18,400 patients per year exists. Hence, between 45% and 60% *excess* capacity exists in the current network of radiotherapy services in Wisconsin.

As some of these units have very small volumes,[3] those estimates of excess radiotherapy capacity are quite conservative. The need to combine or phase out units is apparent. Both quality and economy of care is affected by unneeded resources. It is critical that marginal units are merged and that increasing efficiency of existing units receive priority consideration. Investments in additional equipment should be scrutinized with great care to insure adequate caseloads and sensible growth on both a district and statewide basis. A moratorium on new units may be needed to achieve optimum care and care economics.

The information contained in this report can doubtlessly be improved. However, it is our opinion that these standards and their implications represent the best information available and provide a reasonable basis for agencies to estimate needs and to review proposals for radiotherapy centers.

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2. R. Holmes, MD: *Treatment Care in Wisconsin,* submitted to the Governor's Health Planning and Policy Task Force, dated July 1972 as revised.
3. R. Deffebach, MD: *Patterns in Cancer Care—Some Planning Suggestions,* November 1971. □

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gs—Not recommended during the first and trimester of pregnancy. Caution patients sible combined exaggerated effects with , barbiturates, tranquilizers or other CNS ants. Exaggerated effects might result in of vision, paralysis of accommodation and d hypnosis. Caution patients concerning a motor vehicle, operating machinery, or azardous operations requiring alertness af- ng the drug. ADMINISTER WITH CAUTION IENTS WITH SUICIDAL TENDENCIES AND T PRESCRIBE LARGE QUANTITIES OF THE Adjustment of the dosage of oral anticoag- might be necessary when beginning ethchlor- herapy, during therapy, or after stopping . This drug is not recommended for use in n. PLACIDYL HAS THE POTENTIAL FOR EVELOPMENT OF PSYCHOLOGICAL AND CAL DEPENDENCE. INSTANCES OF SE- WITHDRAWAL SYMPTOMS, INCLUDING ILSIONS AND DELIRIUM CLINICALLY SIM- TO THOSE SEEN WITH BARBITURATES, BEEN REPORTED IN PATIENTS TAKING AR DOSES AS LOW AS 1000 MG. PER DAY A PERIOD OF TIME WHEN THE DRUG WAS NLY DISCONTINUED. PROLONGED AD- TRATION OF THE DRUG IS NOT RECOM- ED. Addiction-prone patients or those who ely to increase dosages of the drug on their itiative should be observed for evidence of or symptoms which may indicate possible vithdrawal or abstinence symptoms. Signs mptoms associated with withdrawal and ab- e include unusual anxiety, tremor, ataxia, g of speech, memory loss, perceptual dis- s, irritability, agitation and delirium. Other ell defined signs and symptoms, not neces- due to withdrawal and abstinence, may in- anorexia, nausea or vomiting, weakness, ss, sweating, muscle twitching and weight Abrupt discontinuance of Placidyl following ged overdosage may result in convulsions lirium.

itions—Toxic amblyopia has been reported ong-term continuous use of ethchlorvynol. nent visual defects have been observed, al- amblyopia has improved after discontinua- f the drug. Drug dosage should be limited erly and debilitated patients to the smallest ve amount. If pain is present, this drug only be given if insomnia persists after s controlled with analgesics. Caution is ad- in prescribing the drug for patients who are treated with either MAO inhibitors or anti- ssants. Transient delirium has been reported he combination of Placidyl and amitryptyline. dosage should be reduced if prescribed for ts receiving MAO inhibitors or antidepres- Caution should be exercised in patients mpaired hepatic or renal function. Patients espond unpredictably to barbiturates or alco- r who exhibit excitement and release of inhi- in association with such agents, may also in this way to Placidyl. Rarely, patients may t symptoms suggestive of an unusual sus- ility to the drug; such as prolonged hypnosis, nd muscular weakness, excitement, hysteria, cope without marked hypotension. Transient ess or ataxia may occur.

se Reactions—Hypotension, nausea or vom- gastric upset, aftertaste, blurring of vision, ess, facial numbness, and allergic reaction d by urticaria have been reported following yl administration. Mild "hangover" and symp- of mild excitation have occurred in some ts. There have been rare reports of cholestatic ce occurring in patients taking ethchlorvynol. cases of thrombocytopenia have been re- l in patients receiving ethchlorvynol. 305432

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CASE REPORT

Tibial Resonant Frequency in Paget's Disease

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PAGET'S DISEASE (osteitis deformans) is a chronic affliction of bone which affects an estimated 3% of the population beyond 40 years of age.[1] The incidence increases to about 10% of the population above 90 years of age.[2] The disease has a chronic course with periods of relative inactivity followed by periods of more progressive changes.[3]

Paget's disease is divided into early and late phases.[4] The early phase is characterized by increased osteoclastic activity with hypervascularity and destruction of normal bone architecture. At this point, the bone is soft. Accessible bones may often be indented by finger pressure. In the later phase, there is less vascularity and less osteoclastic activity. The disease is then characterized by bony remodeling in a random pattern resulting in the typical mosaic appearance on microscopic examination.[5,6,7]

The most frequent complication of Paget's disease is fracture.[1] Early in the disease, the most common fracture is "Codman's rotten wood type." Microfractures are also present and are commonly called "Looser's line."[4] As the disease progresses, deformity of the long bones takes place. Anterolateral bowing of the tibia typically occurs if it is extensively involved.[1]

One of the major problems in patients with advanced Paget's disease is determining how much activity is permissible. This is especially true when Paget's disease involves the long bones. Questions that usually occur to the physician are: (1) May the patient be active in sports? (2) Should I advise the patient to use crutches, a cane, or a wheelchair

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and if so, how long? These questions are related to more basic questions: (1) How weak are his bones? (2) How likely is he to fracture his bones? The usual approach in resolving these questions is to take serial x-ray films and then estimate the strength of the patient's bones from their radiographic appearance. This, however, is quite subjective. In an attempt to quantitate the strength of a long bone involved with extensive Paget's disease, we determined its resonant frequency in vivo by a technique previously described in the literature.[8] The following is a case report of a patient with extensive left tibial Paget's disease.

Case Report

The patient is a 57-year-old white man with Paget's disease that was first diagnosed in 1967. At that time, he was having pain and swelling in the left proximal tibia. X-ray studies were compatible with Paget's disease. Since 1967, he has limited his activities and has had no particular problems except that his left shin is more prominent and his left leg is slightly bowed relative to the right.

He was admitted to the hospital in July 1972 with the chief complaint of chest pain. Nine days later he underwent open heart surgery for coronary occlusive disease. Ten days later he stepped out of bed and had sudden pain in the left leg below the knee. X-ray films demonstrated an avulsion fracture of his left tibial tuberosity and extensive Paget's disease involving its proximal two-thirds.

The patient was treated in a long leg cast in extension for 12 weeks. At this time he was without pain, had good quadriceps function, and was able to ambulate. The resonant frequencies of his left and right (to serve as a control) tibiae were measured. X-ray films of the left tibia showed extensive Paget's disease as noted above (Fig 1). Those of the right tibia were read as normal.

Figure 1—Extensive Paget's disease left tibia.

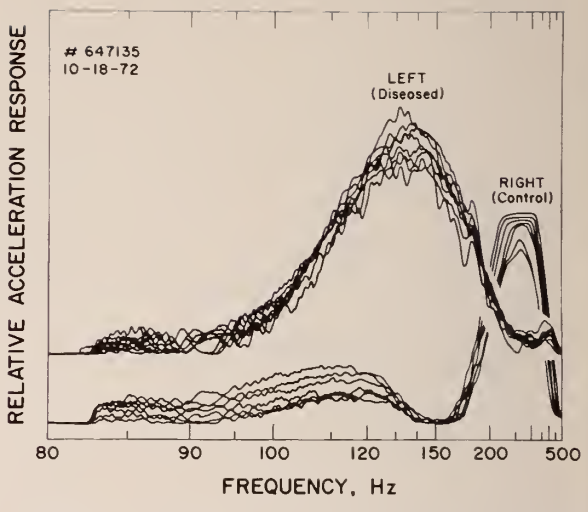

Figure 2—Tibial response spectra. Note the lower resonant frequency (135 Hz) on the involved side as compared to the normal side (277 Hz).

The resonant frequency of the left (diseased) tibia was 135±4 (standard deviation) Hertz (mean of 8 determinations). The resonant frequency of the right tibia was 277±11 Hertz (7 determinations). Beam theory[9] suggests that the strength of the diseased tibia, in percentage terms relative to the uninvolved tibia, is given by $(F_f/F_c)^2 \times 100\%$, where F_f is the resonant frequency of the diseased, F_c is the resonant frequency of the normal tibia, respectively. Substitution of the data for this patient shows that $(F_f/F_c)^2 = 0.238$. Therefore, the left tibia is about 24% as rigid as the right. Figure 2 shows the left and right tibial response spectra of this patient.

Comment

This 57-year-old patient with extensive Paget's disease of the left tibia has been presented in order to demonstrate the potential value of determining resonant frequency. This procedure may ultimately allow the clinician to obtain a quantitative, objective estimate of the strength of a long bone involved with Paget's disease. It is hoped that this procedure will allow the clinician to determine: (1) the risk of fracture and (2) the degree of healing which has taken place following such a fracture; and, therefore, when splinting and ambulatory aids are required.

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The Drug Abuse Program at the Milwaukee County Institutions —After Two Years

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THE DRUG ABUSE PROGRAM at the Milwaukee County Institutions was initiated in August, 1969, in response to the increasing problem of drug abuse throughout the State of Wisconsin. The program was directed at the drug abusers in Milwaukee County, by providing them with a means of obtaining medical treatment for their drug problems, primarily on an outpatient basis. After six months of operation, a report was published characterizing the 87 patients who had entered the program.[1] After two years, more than 550 patients had entered the program. This study intends to show demographic and epidemiologic data concerning this population of drug abuse patients.

The term "drug abuse" may be defined as a non-medical or socially unacceptable use of drugs which are taken intentionally to produce an altered state of mind. The whole spectrum of drug abuse from aspirin through heroin was involved. Patients on heroin were most often referred by fellow-heroin addicts who had received treatment. Patients with abuse of marihuana, hallucinogens, amphetamines, inhalants, and barbiturates were often referred for evaluation and possible treatment by other community agencies, private physicians and catchment area outreach stations. Prisoners brought by police to the hospital for emergency treatment were also interviewed. Patients hospitalized for other medical reasons were seen on consultation. Except for a few patients committed by the courts, all patients who came to the program were admitted on a voluntary basis.

The functions of the Drug Abuse Clinic are several-fold. The patients are evaluated as to the type and severity of drug abuse, and appropriate referrals are made as necessary, to psychiatry, social service or other agencies. Those patients with physical addictions, primarily heroin and barbiturate users, are admitted for inpatient detoxification. Other patients are entered into outpatient abstinence, follow-up, and counseling. Patients with heroin addiction and previous failures at abstinence may be placed on an outpatient methadone maintenance program. It is not the purpose of this study to describe these functions in any detail.

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Methods

The subjects of this study are 551 patients who have been interviewed in the Drug Abuse Clinic from August, 1969, to November, 1971. At the time of initial patient contact, a questionnaire was completed for each patient requesting the following information: age, sex, race, education, employment, criminal record, first drug experience (drug and age at time), present drug habit (drug, year began, amount used per day, cost per day, and means of support), and other drugs abused. The data recorded on these questionnaires was utilized in constructing the following graphical and tabular interpretations.

Results

The 551 patients treated in the program included 398 opiate-dependent persons of whom 376 used heroin almost exclusively. In addition, there were 24 barbiturate abusers, 13 amphetamine abusers, 10 marihuana abusers, and 42 others with mixed oral drug abuse or use of various non-opiate drugs. The remainder of the population consists of 64 patients who denied any regular use of drugs but would experiment off and on with non-opiate drugs, primarily marihuana, LSD, amphetamines, and barbiturates.

For simplicity in presenting interpretation of the drug abuse and socio-economic characteristics of patients in the program, the drug abusers have been divided into two main groups: the 398 opiate-dependent patients comprise one group and the 153 abusers of all other drugs form the other. The opiate-dependent group consists of patients who were physically addicted to opiate drugs, primarily heroin. The other group includes all patients with non-opiate drug abuse problems.

Comparison of Age, Sex, Race, and Criminal Record Characteristics Between the Opiate and "Other" Drug Abusers

Table 1 presents an overall numerical breakdown of the entire population of drug abusers. The male-to-female ratio is about 3 to 1 in both opiate and "other" drug abusers. Large numbers of blacks and Spanish–Americans are present among the almost 400 opiate-dependent patients. The average age of the opiate user is 29, and over one-half have criminal records. The 153 "other" drug abusers are younger, averaging 24 years, and made up primarily of

TABLE 1—*Distribution of patient population between opiate and other drug abusers according to their age, sex, race, and criminal record*

	no. of patients	Ave. age	Sex		Race				Criminal record
			Male	Female	White	Black	Span. Amer.	Other	
OPIATE	398	29	300	98	128	190	75	5	212
OTHER	153	24	114	39	125	18	3	7	27
TOTAL	551	27	414	137	253	208	78	12	239

whites. Less than one-fifth of this group have criminal records.

Figure 1 shows the age distribution of the entire population, with the age group plotted against the percentage of the total patient population. The largest group of patients falls in the 15-to-24-year age bracket and, although the average age of the opiate abuser is 29, the largest group of these opiate-abuser patients also falls within the 15-to-24-year-olds. The percentage of other drug abusers is largest in the 15-to-24-year-old group and decreases in proportion to opiate abusers in each succeeding age bracket.

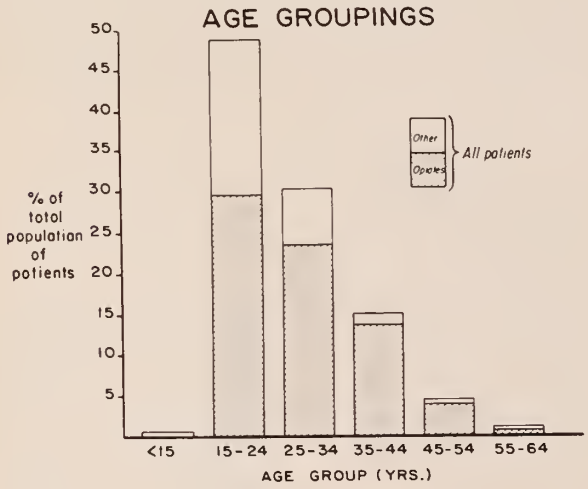

Figure 1—Age distributions of the total population of opiate and "other" drug abusers.

In Figure 2 the entire population has been graphed according to age group, race, and sex in relation to the percentage of the total patient population.

More than one-half of all patients were in the 15-to-24-year age group and the vast majority of this group were Caucasians. In succeeding groups, the proportion of whites to the minority groups decreases.

Figure 3 is a graphic representation of the opiate abusers divided as to age group, race, and sex in relation to the percentage of the total population of patients. The majority of the white opiate-dependent patients are in the 15-to-24-year age bracket, with rapidly decreasing numbers in succeeding age groups. The largest group of black opiate-dependent patients is found in the 25-to-34-year age group, with a more even distribution over the three brackets between 15 and 44 years of age. The Spanish–American opiate abusers have about equal percentage in the 15-to-24-year and 25-to-34-year age brackets.

Comparison of First Drug Experience Between the Opiate and "Other" Drug Abusers

Table 2 illustrates initial drug experiences of the opiate and "other" drug abusers in percentage of each group. Also presented is the average age of the patients at the time of their first drug experience. In the opiate-dependent group, about one-fourth began their drug abuse with an opiate while over one-half first used marihuana. A very small percentage (about 4%) of persons in the other group began with opiates, but both groups had equal pro-

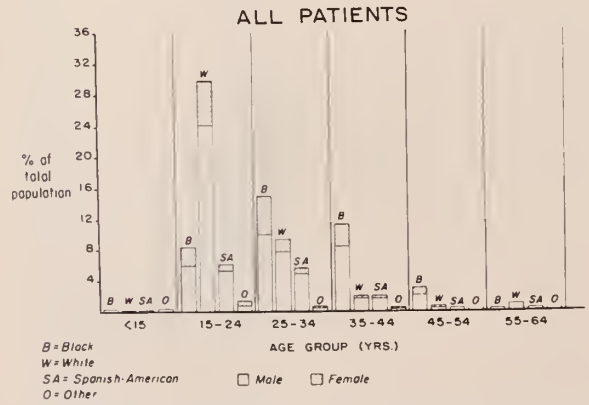

Figure 2—Percentage of the total population based on age, race, and sex.

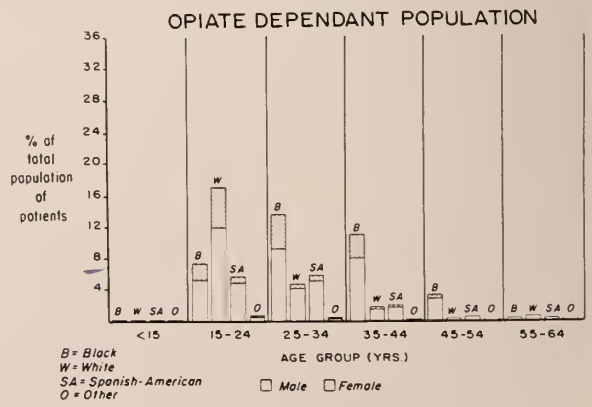

Figure 3—Distribution of opiate abusers in percentage of the total population according to age, race, and sex.

TABLE 2—*Average age of onset and initial drug experiences of opiate and other drug abusers*

	Heroin		Codeine or Cough Rx		Morphine		Barbi-turates		Amphet-amines		Marihuana Hashish THC		Hallucino-gens (LSD)		Cocaine		Alcohol *		Others	
Present Drug Abuse	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age	%	Ave. age
OPIATES	17.3	22	5.6	17	1.3	18	3.3	18	6.2	18	53.2	17	2.0	21	0.8	14	2.8	15	7.5	**
OTHER	1.9	13	1.9	**	0	**	5.7	31	10.6	18	49.7	18	10.7	19	1.9	16	4.4	15	13.2	**

* Patients were not specifically asked if they first used alcohol and are included here only if they had listed their initial drug experience as alcohol.

** Ages not available.

portions of persons trying marihuana first, about half in each group.

Among the opiate abusers, the average age of initial abuse with heroin was 22, as compared with 17 for those who first tried marihuana. Among the "other" drug abusers there were insufficient numbers who began with opiates to indicate a meaningful age, but those whose first experience was with marihuana had an average age of 18 years.

Comparison of Employment and Student Status and Educational Level Between the Opiate and "Other" Drug Abusers

Table 3 gives the percentage of opiate and "other" drug abuser populations divided according to race, as to employment or student status at the time of initial interview. This table gives an indication of the number of drug abusers in the work force of the community. Three-fourths of the black opiate users were unemployed, with decreasing amounts of unemployment present in the Spanish and white populations respectively. Among the "other" group, the percentage unemployed was about the same as in the opiate group for the white and black populations. The number of unemployed Spanish–Americans among the "other" drug abusers was too small to draw any interpretations.

Most drug abusers have completed an average of eleven grades, with the exception of the Spanish–American opiate abusers who have completed an average of nine years education.

Yearly Incidence (in percentage) of Beginning Opiate Addiction in This Population

Data showing the year in which opiate dependence began was available for 376 of the 398 opiate-dependent persons. These 376 persons were grouped according to the year

TABLE 3—*Percentage of employment among opiate and non-opiate abusers based on their race and years of education*

		% Employed	% Unemployed	Student	Ave. education in years
OPIATE	White	30	56	14	11.8
	Black	22	75	3	11.1
	Spanish-American	35	62	3	9.2
OTHER	White	29	53	18	11.7
	Black	17	72	11	11.4
	Spanish-American	*	*	*	*

* Insufficient number.

TABLE 4—*Percentage of opiate abusers with criminal records according to race*

Race	No Record	Probation	Incarceration 1-6 mos.	Incarceration 7-24 mos.	Incarceration 24 mos.
White	59	18	6	8	9
Black	44	5	13	13	25
Spanish American	56	3	12	8	21

of initial opiate experience. The number of these persons beginning addiction to opiates in each year was then expressed in percentage, and we arrived at an epidemiologic picture as shown in Figure 4. The graph shows a relatively stable small percentage for each calendar year without apparent trend for the years 1930 through 1966. Over one-half of this population of opiate-dependent patients have begun their habit since 1967, with progressive increases through 1970. Most persons with opiate dependence do not seek treatment before a year has elapsed. Therefore, the actual number of persons we have seen becoming addicted in 1971 is lower than those who began their habit in 1970.

The length of opiate (heroin) addiction for these patients may be approximated from the graph by considering the time between the initial year of opiate abuse and the two years (August, 1969, through November, 1971) in which patients have been interviewed in the drug abuse program.

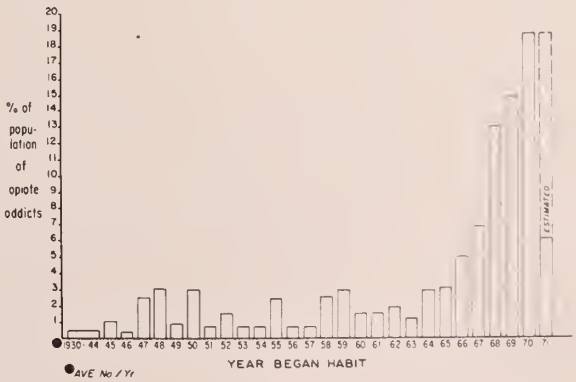

Figure 4—The incidence of initial opiate abuse among this population in the last 40 years.

The Cost and Means of Support of Opiate Habits

The cost of supporting an opiate habit (primarily heroin) among patients in this population ranges from $20 to $300 per day, with an average of $65 per day. Almost two-thirds of the opiate-dependent patients support at least a portion of their habits by illegal means, including burglary, shoplifting, prostitution, and selling drugs.

Criminal Records of the Opiate Abusers

Table 4 represents the criminal record of opiate-dependent patients in relationship to each race and according to the number of months spent in jail. The length of jail terms ranges from none to well over 10 years. Of the 376 opiate abusers from whom the data was available, over one-half have no criminal record. Well over one-half of the white opiate-dependent patients have no jail records and an additional one-fifth had only probation. Among the blacks, 25% served over two years in jail. Similarly, 21% of the Spanish–American opiate abusers have served over two years in jail. For all those opiate abusers who have served two or more years, the average length of opiate addiction was 13 years.

Discussion

The Drug Abuse Program at the Milwaukee County Institutions provides the only facility for non-veterans in the community able to handle large numbers of heroin- and barbiturate-dependent persons. In the community there are other agencies that are able to provide adequate counseling to soft drug abusers. Because of this, a very large percentage of the patients on our program are opiate-dependent. There are 8 opiate abusers for every 3 of all other varieties among those who have entered this program.

Persons who came to the Drug Abuse Program for heroin dependence had an average age in the late 20s, whereas those who came to the Program for all other varieties were several years younger, mostly in their early 20s. In the age group of 15 to 24, the white population outnumbers all other races combined, whereas the whites compose a decreasingly small percentage of each older age group category. In the past opiates were mostly used by blacks and Latins. These figures indicate that the spread to the whites and to the young is of relatively recent occurrence.

In our previous study of 87 drug abuse patients, we found the ratio of 5 men for every 2 women. In this larger study, the ratio has shifted slightly to show 3 men to every woman.

It is difficult to assess the proposition that there is a progression of drug abuse from marihuana to heroin. In this population, over one-half of the opiate-dependent patients had their first drug experience with marihuana. This history does not provide any solid evidence that the use of marihuana results in the eventual use of heroin and other opiates. Almost one-quarter of the opiate-dependent population actually began their drug experiences with opiates, and subsequently found no other illegal drug to take its place. This indicates that heroin addiction most often begins with heroin experience. If heroin addiction began with marihuana experience, we should have many more heroin users than we have. Environment, crowded living conditions, break-up of families, or association with other peer group users is more inducive to the heroin habit. Most of the drug abusers began using drugs at an early age, usually the late teens, but most were in their middle to late 20s at the time they sought treatment. This indicates that it takes some time for a person to become dissatisfied with the drug culture life-style. This dissatisfaction is the chief motivation for voluntary treatment.

The employment characteristics of the patients interviewed showed that the blacks had the highest percentage of unemployed among both opiate and "other" drug abusers. The educational level of all patients was below the national average. All patients had completed an average of 11 years education with the exception of the Spanish–American opiate abusers, who had completed an average of 9 years education. The high unemployment among the blacks parallels that of the black community throughout the country and is probably related to race rather than drugs.

The magnitude of the heroin addiction problem in Milwaukee County can be estimated by the number of opiate abusers who seek treatment from this Program. A significant trend in the demand for treatment is evident. There has been a sharp upswing in the number of persons who began their addiction since 1967. Over half this population of opiate-dependent persons began their habit since that year, with progressively increasing numbers through 1970. Most heroin addicts do not seek medical assistance for their abuse until after one year. Therefore, the figures for opiate addiction beginning in 1971 are incomplete. However, judging from the patients seen on the Program since the statistics for this paper were compiled, an estimate can be projected to be at least equal to the rate seen in 1970.

The heroin addicts interviewed for the Drug Abuse Program spend an average of $65 per day to support their habits. This compares with the daily cost of $60 in 1969 and reflects the general inflationary trend of the economy. Every untreated addict represents a heavy burden on the community. The money spent by the average opiate-dependent person amounted to $23,722 per year for heroin alone. Effective treatment can cost as little as $1450 per patient per year.

Almost two-thirds of the patients supported at least a portion of their habit by illegal means, and over one-half have criminal records. Twenty-five

percent of the black and 21% of the Spanish–American opiate abusers have served jail sentences in excess of two years, while among the whites only 9% have spent that much time in jail. In addiction, 18% of the whites have been given probation, while only 5% of the blacks and even fewer Spanish–Americans have criminal records limited to probation. The black and Spanish–American opiate abusers present an older group with long histories of drug abuse. As the duration of the opiate dependence becomes longer, the occurrences of incarceration become greater. Those patients with over two years in jail have an average duration of heroin abuse of about 13 years. In this population, blacks and Latins have been incarcerated more frequently than whites. This could have more to do with the duration of addiction than the race of the opiate-dependent person. The majority of the white opiate abusers are young and began their habits since 1967.

Summary

Five hundred and fifty-one drug-dependent persons from the Metropolitan Milwaukee Area entered this Program. Men outnumbered women three to one. Black and Latin opiate users constituted the majority of those opiate abusers over age 25, but whites predominated among opiate abusers under age 25. The average age of opiate-dependent abusers was 29, while that of the other drug abusers was 24 years. Initial use of marihuana seems to have no definite cause-effect relationship to subsequent addiction to heroin. Dissatisfaction with the drug lifestyle takes time to develop; therefore, early treatment is unusual for persons with drug dependency. Blacks had the highest percentage unemployed. They also have longer duration of addiction, a higher percentage with criminal record, and a lower percentage of probation. Of the opiate-dependent persons studied, 238 of 376 have become addicted between January, 1967, and November 1971, and the majority of these are white. The average amount of money spent by the opiate-dependent person was $65 per day, $1950 per month or $23,725 per year. Treated opiate-dependent persons can better themselves and at the same time add to the productivity and wealth of the community. Over half of those dependent on opiate drugs had criminal convictions; therefore, incarceration does not appear to be the answer. Incarceration has been expensive for the taxpayer, miserable for the individual, and so far has been mostly ineffective in preventing re-addiction to heroin after release.

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Medical Recommendations and the National Commission on State Workmen's Compensation Laws

GEORGE A. HELLMUTH, MD, Medical College of Wisconsin, Milwaukee, Wis: *Indust Med & Surg* 41: 20–24 (July) 1972.

As the creation of the National Commission on State Workmen's Compensation Laws by the federal Occupational Safety and Health Act of 1970 suggests that reform of state workmen's compensation laws may be undertaken by Congress, uniform and comprehensive medical-legal guidelines for the effective implementation of the medical aspects of workmen's compensation are presented and urged for consideration in any program to improve workmen's compensation systems.

The proposed guidelines, reported in the July 1972 issue of *Industrial Medicine and Surgery*, designed for uniform application to the laws of the various states, provide for the establishment of medical advisory departments within workmen's compensation administrations. These departments would advise and assist commissions on medical causation and impairment, prevention, medical care, and rehabilitation and vocational services; mediate complaints in the medical area; develop policy statements, interprofessional codes, peer review procedures, and medical guidelines; oversee and evaluate medical reports; provide liaison with rehabilitation facilities; establish panels of physicians to provide care in cases of industrial illness or injury; investigate the medical aspects of claims, when necessary; help determine claim-related medical fees; urge post-mortem examinations in fatal cases; establish panels of independent, impartial medical witnesses; urge pre-trial conferences in disputed cases; urge provision of rehabilitation services; and keep statistical records on work-related injuries, illnesses, and deaths, services and dispositions of cases.

It is also suggested that a united medical profession, including state medical societies, intersocieties and academic medical centers, make available its resources to improve the medical aspects of workmen's compensation systems for the protection of our labor force. □

Cancer Registries and Their Usefulness in Wisconsin

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IN WISCONSIN THERE are 151 hospitals involved in the care of cancer patients. One hundred and twenty-six hospitals were recently surveyed to determine the number of cancer patients cared for in each hospital. Twelve hospitals were unable to give statistics relating to cancer diagnoses and 5 hospitals were unwilling to tabulate this information.

The results of the survey indicated that of the 109 hospitals responding to the survey, 14 hospitals (12.8%) have cancer registries without functioning tumor boards (cancer committees), 4 hospitals (3.7%) have tumor boards without cancer registries, and 32 hospitals (29.4%) have both cancer registries and tumor boards. Of the 32 hospitals having both cancer registries and tumor boards, 9 of these hospitals could not give the total number of cancer patients seen at their hospital during 1970 or 1971. Fifty-nine (54%) hospitals in which physicians treat cancer patients have neither a cancer registry nor a tumor board. Forty-eight of these hospitals surveyed (34.1%) were able to give the total number of discharges for a given year in addition to the total number of new cancer patients cared for within their hospital during the same year. The remaining 16 hospitals could provide only the total number of cancer discharges but not the total number of cancer patients.

According to the national average there should be 24,000 new cancer patients diagnosed in Wisconsin each year. It is inexcusable that the treatment administered to more than 50% of the cancer patients cannot be evaluated because of the lack of a tumor board and cancer registry. Only one method guarantees our knowing the incidence, ramifications and success of treatment for cancer as a disease and that is by maintaining a complete, up-to-date registry, collecting core data, and having a functioning hospital tumor board which meets at least once a month.[1] That is what constitutes a hospital-based "Cancer Program."[2]

The ease with which a cancer program is organized depends upon several factors: the acceptance by physicians of the need for continual objective evaluation in order to maintain high standards and improve, when necessary, cancer diagnosis and management; hospital administration giving moral support to the tumor board and adequate financial support to the cancer program; employment of intellectually competent registry personnel who have an awareness of the significance of their role in relation to the success of the overall cancer program; cooperation from the Medical Record Department and organized assemblage of medical record data which should contain complete documentation of medical care.[3] The success of a cancer program will definitely be inhibited if any of these factors does not exist.[1,4,5]

It is inexcusable that the treatment administered to more than 50% of the cancer patients cannot be evaluated because of the lack of a tumor board and cancer registry.

A cancer registry without a functioning tumor board is a wasteful hospital expenditure. As long as the hospital has a non-functioning tumor board the registry will be a repository of unused data. An active tumor board without a cancer registry may provide patients with a multidisciplinary approach regarding the type of treatment to be administered, provided patients are presented and discussed before treatment has been initiated. It is important, however, to be able to evaluate this treatment at a later time but not as an individual case. To achieve more meaningful results it is essential to compare and evaluate a single case with other cases in a similar "group environment" which is representative of the total scope of a hospital's experience.[1,6]

Physicians and administrators immediately assume that the cancer registry should be part of the Medical Record Department. Although this is an ideal location for the cancer registry, it is best that the cancer registry have functional autonomy from the Medical Record Department. A physician should be appointed to supervise the cancer registry. He should be someone other than the chairman of the tumor board. Since the chairman may change, the

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registry supervisor should have a permanent position. Cancer registry personnel should attend all tumor board presentations. These provide an excellent learning experience.[7]

Much discussion has centered around the usefulness of a central registry for cancer. If a central cancer registry is to help improve cancer patient care, it must improve the quality of cancer programs and data collection methods of as many hospitals as possible within a defined area.[8]

A cancer registry without a functioning tumor board is a wasteful hospital expenditure.

The central registry must have an organized training program designed to train hospital personnel to abstract relevant data with accuracy and consistency by screening the entire medical record and to assist whenever possible in the overall functions of the cancer program. The central registry must facilitate the retrieval of data collected within the individual hospital. It is essential that the Central Registry enable the hospital's cancer program to function independently of the central registry.[9]

In Wisconsin since January 1971, many individuals have become involved in promoting the establishment of uniform cancer programs for our state. An automated data collection system has been developed for collating cancer-related data. The program is titled Cancer Review and Emendation (CaRE). CaRE maintains quality-controlled, up-to-date information on all cancer patients seen at the participating hospitals. Follow-up capabilities are provided through computer-generated lists and letters on all patients from date of entry until death. It also is capable of providing other hospitals with information concerning cancer patients. It provides, in addition, a broader basis for more informative reports on incidence data, general diagnostic and treatment evaluation, and research applications. In addition to giving hospitals information which can be used to improve patient care, attention is given to the individual hospital's cancer program to try to insure maximum utilization of its data.[10]

If a central cancer registry is to help improve cancer patient care, it must improve the quality of cancer programs and data collection methods of as many hospitals as possible within a defined area.

The CaRE Program is continually expanding to include additional hospitals. Twenty hospitals are currently participating with the total bed capacity of 6,222 which represents 26% of the number of hospital beds available to cancer patients in Wisconsin. In order to continually expand, while maintaining quality control on data collected, registry personnel at participating hospitals are trained in cancer methodology and their work periodically evaluated to ascertain their progress, accuracy, and consistency. This also helps in achieving similarity in coding expressions.[11]

CaRE is one of approximately 30 central registry systems for cancer data collection in the United States but it is the only one that is coordinated with a hospital-wide program of cancer meetings, committees, and consultations which hopefully will insure the utilization of data and thereby improve cancer patient care.[5] CaRE personnel are participating in a national committee for establishing uniform standards for data collection and its utilization among central registries and cancer centers.

An automated data collection system has been developed for collating cancer-related data . . . Cancer Review and Emendation (CaRE).

Today more than ever it is essential that physicians provide a means for self-evaluation and self-improvement to show past, present, and future achievements in the area of cancer patient care. They owe it to their patients, their profession, and themselves to demonstrate that as a provider group they are able to be objective in evaluating their own capabilities and performances.

Today more than ever it is essential that physicians provide a means for self-evaluation and self-improvement.

The concept of self-evaluation and improvement is ancient and applicable to areas other than cancer patient care. The principle was enunciated 2,000 years ago by St. Paul in his epistle to the Galatians: "For if a man thinketh himself to be something when he is nothing, he deceiveth himself. But let each man prove his own worth and then shall he have his glorying in regard of himself alone, and not of his neighbor."[6]

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Epidural "Blood Patch" for the Treatment of Post Spinal Puncture Headaches

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THE ETIOLOGY OF post spinal tap headaches is believed due to the loss of spinal fluid through the dural puncture site. This loss exceeds its replacement by the choroid plexus and hypotension of spinal fluid occurs. The decrease in hydrostatic pressure may produce tension on the supporting structures of the brain and thus cause a headache.

The fact that low spinal fluid pressure is found in most, but not all, patients with post lumbar puncture headaches has been definitely established. However, not all patients with a decreased spinal fluid pressure manifest a headache. The degree to which the spinal fluid pressure must be lowered to create a headache is not definitely known.

Causes for Hypotension of Spinal Fluid

The larger the needle size used for the spinal tap, the greater the defect in the dura allowing the fluid to exit and the greater is the incidence of a headache. There are numerous statistical analyses relating the needle size to the incidence of headaches.[1–5]

It has been shown that a hole in the dura may not heal for six days to two weeks. Myeloscopic examination of patients frequently reveals large collections of fluid in the epidural space when an ordinary lumbar puncture had been performed within the previous 2 to 4 days.[6]

Traditionally, post spinal tap patients have been instructed to lie flat in bed for 12 to 24 hours. Our experience has convinced us that many of the so-called spinal headaches are iatrogenic. The surgeon, nurses, and paramedical personnel tell the patient that he must lie flat or he will get a spinal headache. If he inadvertently sits up and gets caught, or remembers the nurse's instruction, he immediately lies down to accept the headache that is certain to come.

Although the incidence of post lumbar puncture headaches reported varies from 0.5% to 60%, the average is between 10% and 15%. Using a 25–26 gauge needle, the incidence of headaches usually remains below 1%. However, utilization of the small bore needle can be very awkward without the aid of a previously inserted introducer. Care must be used in placing the introducer to prevent a subarachnoid puncture before positioning the fine gauge spinal needle. In using the small pencil point spinal needles, it may be difficult to see spinal fluid returning into the needle. If the patient is instructed to bear down as in a Valsalva maneuver, there will be an increase in cerebral spinal fluid pressure and the fluid readily returns, assuming proper placement of the needle.

Symptoms of a Post Spinal Headache

The most common symptom is a postural headache which occurs on sitting up or standing and is relieved by lying flat again. The headache may begin immediately on assuming the erect position or be delayed for several hours. Patients usually describe an occipital or bifrontal aching but it can occur any place in the calvarium.

The mechanism of this type of headache fits the theory of spinal fluid hypotension. When the patient assumes an upright position, the shock-absorbing effect of the spinal fluid may be absent or diminished and the brain may actually sag producing tension on the tentorium and meningeal structures, particularly about the base of the brain.

Methods of Restoring CSF Pressure

Methods of elevating the spinal fluid pressure have included intravenous alcohol, abdominal pressure through the use of abdominal binders, hydration with or without antidiuretics or sodium-retaining steroids, and spinal and epidural injection of dextrose or saline.

The relief observed on abdominal compression may very well be the result of compression of the inferior vena cava with consequent engorgement of the peridural and meningeal veins. This would be expected to result in a relative increase in the vertebral cerebrospinal fluid pressure and tend to prevent the shift of the brain caudad.

Restoring the cerebrospinal fluid pressure to normal by subarachnoid injection of 30–50 ml of saline relieves the headache almost immediately. However, this is transient and the headache usually returns again some one to two hours later. When 30 ml of saline is injected into the epidural space, the headache is relieved in minutes. But unfortunately the headache usually returns in a few hours and repeated injections are necessary. It appears that the

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most effective method of restoring cerebral spinal fluid pressure is to "patch" the dura or place a sealing material adjacent to the arachnoid puncture, while normal healing measures produce a permanent closure. Next hydrate the patient so that he can restore his cerebral spinal fluid volume. Dehydration prior or following the dural puncture results in a lack of body water for the choroid plexus to draw from in forming new cerebrospinal fluid. The patching technique, using homologous blood was first described in 1960 by Gromley.[7] Subsequently, DiGiovanni and Dunbar[8] reported excellent results using epidural injections of autologous blood for the treatment of 41 patients having post lumbar puncture headaches.

In 1965, Ozdil[9] did a study in which he injected a blood clot through the spinal needle following routine spinal anesthesia. Approximately 20 minutes prior to lumbar puncture, he drew 2.5 ml of the patient's blood and placed it in a sterile medicine glass on the spinal tray. Immediately preceding the spinal tap, the clot was transferred to an insulin syringe. After injection of the spinal drugs one-third of the blood clot was injected in the subarachnoid space and the remainder in the epidural space. This study was performed on 200 patients, one-half of whom received the prophylactic blood clot while the other half acted as the control group. There were no headaches in the treated group whereas the control group had a 15% incidence of headache.

Blood Patch Method

In our series, 60 epidural "blood patches" were done on patients manifesting symptoms of a post spinal headache. The criteria for diagnosis of a post lumbar puncture headache was the presence of a headache accentuated by the upright position and relieved in the horizontal position. The majority of these patients received lumbar punctures with 18, 20 or 22 gauge needles for diagnostic taps, myelograms, or obstetrical saddle blocks.

Technique

The patient is placed in the lateral position, prepped and draped as for a lumbar puncture. Using the air syringe technique an 18-gauge Tuohy needle is placed in the epidural space utilizing if possible the same interspace as for the previous spinal puncture. An assistant withdraws 5 ml of blood from the antecubital fossa under aseptic conditions. This syringe is then attached to the Tuohy needle and the blood is injected into the epidural space. After the needle is withdrawn, the patient is placed supine and asked to drink a liter of water over the next hour. Occasionally we have infused 1000 ml of Ringer's lactate solution through the previously used intravenous needle. One hour after the procedure, the patient is asked to sit up and is allowed to walk about the ward. Frequently patients manifest some momentary vertigo on assuming the erect position, but almost all comment that their headache has been relieved. Many continue to have some "soreness" about the neck musculature which we feel is due to splinting because of the previous headache and this is relieved very nicely with meprobamate which possesses the properties of a mild muscle relaxant in addition to being a minor tranquilizer.

Results

In 60 patients receiving this treatment there have been two failures. One was a patient who, in retrospect, probably did not have a true post spinal headache. The other failure was related to a change in the technique described. After 15 trials using the 18-gauge Tuohy needle, it was decided to replace this needle with a blunted 22-gauge spinal needle. We simply filed the sharp point from the needle and reautoclaved it. An 18-gauge sharp needle was used as an introducer with the blunted 22-gauge spinal needle passed through it into the epidural space. There was great difficulty in identifying the epidural space, and the injected blood was most likely deposited outside of this space. Repeating the procedure with an 18-gauge Tuohy needle on the following day produced relief of her headache within an hour. We have used a blunted 22-gauge needle on several other occasions with good results but find the 18-gauge Tuohy needle much easier to use.

Complications

Some of our patients complained of a backache at the site of the Tuohy needle puncture but all agreed that the backache was significantly less of a discomfort than the headache. Because of the backache we used a 22-gauge blunted needle hoping to decrease the incidence of pain. However, there were not enough cases with the 22-gauge needle to arrive at any definite conclusions. On several occasions the Tuohy needle entered the subarachnoid space and spinal fluid drained freely through the needle. On these occasions we withdrew the needle until fluid ceased to flow. Then 2 ml of blood was injected, followed by an additional 3 ml of blood as the needle was withdrawn a further centimeter.

For those patients in whom the subarachnoid space was entered with the 18-gauge Tuohy needle, the headache was not as dramatically relieved and several hours transpired before pain relief occurred. In one patient the headache became much more severe than that experienced prior to treatment. This

severe headache persisted for approximately 12 hours during which time the patient remained in bed and received intravenous fluids.

Summary

The injection of 5 ml of the patient's whole blood into the epidural space produces rapid and dramatic relief of post spinal puncture headaches. In a series of 60 cases excellent results have occurred with no serious complications and few minor side effects.

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Hodgkin's Disease Presenting as "Idiopathic" Thrombocytopenic Purpura

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Thrombocytopenic purpura of the ITP type is an unusual and poorly documented complication of Hodgkin's disease. In a five-year period three patients with Hodgkin's disease presented a clinical picture indistinguishable from classic ITP. Each exhibited marked thrombocytopenic purpura with a normal bone marrow containing increased numbers of megakaryocytes. In two, isologous platelet survival was less than two hours. Spleens were not palpable and splenectomy resulted in one partial and one complete remission. When thrombocytopenia first appeared, the presence of Hodgkin's disease was often unsuspected and in two the spleen was the only site of clinical involvement. Patients with Hodgkin's disease who present this picture, are easily confused with patients who have true ITP, may have an occult recurrence and are likely to have spleen involvement. This complication appears best managed by splenectomy. □

FDA Recalls Amphetamine Combination Drugs

Doctors to Be Visited for Recall Effectiveness

A recall of amphetamine combination drugs, injectable amphetamines and levamfetamine preparations has been announced by the Food and Drug Administration (FDA). Physicians, institutions, and pharmacies may be visited by FDA representatives to check on the effectiveness of the recall. Other state agencies, such as the Wisconsin Board of Pharmacy, are assisting the FDA and the Bureau of Narcotics and Dangerous Drugs in making these visits.

The recall is based on a study by the National Academy of Sciences—National Research Council. Study results led the FDA to these conclusions:

1. Combinations of amphetamines, dextroamphetamines and their salts with other ingredients (for example—tranquilizers, sedatives, vitamins, etc.) do not suffer either in efficacy or in the incidence of adverse side effects from the appetite-suppressant drugs alone.
2. The benefit-to-risk ratio is unfavorable for parenteral injections of amphetamines. Therefore, amphetamines may be marketed in the future only for oral use.
3. Levamfetamine preparations currently on the market have not been shown to be safe and effective for the treatment of obesity.

Not included in the recall are *oral* preparations consisting solely of amphetamine or dextroamphetamine or a combination of the two. Likewise, single entity *oral* methamphetamine preparations are *not* recalled. However, methamphetamine *combinations* are included in the recall.

Examples of products being recalled are:

Ambar 1 & 2	Prelu-Vite Capsules	Biphetamine-T
Appetrol	Desbutal	Bamadex Tablets
Obedrin		

Certain amphetamine-containing drugs are not being recalled at this time. In some cases the sponsors have requested a hearing which must be ruled on. Others have approved new drug applications which must be formally withdrawn before action can be taken. The FDA lists five products which *will not* be recalled at this time:

Obetrol 10 & 20	Bamadex Sequels	Delcobese (all forms)
Eskatrol Spansules	Dexamyl (all forms)	

This information was supplied by the Bureau of Narcotics and Dangerous Drugs, Chicago office. For further information call (312) 353–1423.

Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Current Status of Oral Contraceptives

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An ideal contraceptive agent must (a) be effective, (b) be acceptable to the patient, (c) have reversible effects, and (d) be harmless to the user. The most effective and acceptable contraceptive in use today is the birth control "pill." Despite reports on the occurrence of "post-pill" amenorrhea the reversible effect of oral contraceptives has been amply demonstrated, and amenorrhea following their use is infrequent. With the availability of ovulatory agents the problem is not insurmountable when it does occur. Thus, the first three criteria for an ideal contraceptive agent are satisfied by the "pill."

Regarding the fourth criterion, namely the absence of harm to the patient, great controversy does exist. The important areas in which possible harm may occur with the use of the "pill" can be listed as follows: (1) side effects, (2) metabolic effects, (3) vascular effects, and (4) carcinogenesis. The remainder of this article will discuss these problems.

Side Effects

It is frequently reported that a significant number of patients taking oral contraceptives complain of various unwelcome effects. Depending upon the strength of the preparation used the incidence of such side effects ranges between 15% and 30%. The most commonly noted effects include nausea and vomiting, breast fullness and mastalgia, vaginal discharge and vaginitis, breakthrough bleeding, fluid retention with weight gain, headache, changes in mood, and skin pigmentation.

The difficulty in evaluating these symptoms is that they have been attributed to the oral contraceptives without proper investigation of the prevalence of these symptoms in a random population. Goldzieher,[1] by making use of a placebo-controlled double blind investigation, found that complaints such as headache, nervousness, depression, weight

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gain, and even nausea and vomiting occur with some frequency in normal women. He was unable to show that any of these symptoms, with the exception of gastrointestinal complaints, occurred consistently more often in the pill users than in the placebo group. His study would at least indicate that the true incidence of drug-related side effects is far lower than indicated by the usual uncontrolled investigations.

Metabolic Effects

It is beyond the scope of this discussion to cover all the reported metabolic effects of oral contraceptives. Most of these changes seem to have no physiological significance and therefore need not be dealt with. The major metabolic effects can be summarized as follows:

Hepatic Function

Although several abnormalities in liver function tests have been reported, perhaps the most consistent and significant one is a reversible reduction in bromsulphalein (B.S.P.) excretion. Liver biopsies however have consistently shown no significant abnormalities. From the available data it appears that the development of mild alterations in liver function tests in a healthy user of oral contraceptives does not necessitate stopping the medication unless jaundice appears.

Diabetes

The preponderance of evidence indicates that glucose tolerance is diminished in women taking oral contraceptives. As expected, this impairment is more pronounced in women with latent or overt diabetes. Increased insulin production has been observed in normal women taking oral contraceptives. Among long-term users the glucose tolerance tends to revert to normal while the increased insulin levels persist. Upon discontinuing use of the pill, insulin levels return to normal thus suggesting a capacity of the islet cells to recover following hormonally induced hyperplasia.

It remains to be answered if this pancreatic stress will induce diabetes in normal women or convert latent into overt diabetes. Available data so far tend to negate this possibility.

Thyraid and adrenal glands

Circulating protein bound plasma cortisol and thyroxine increase during use of oral contraceptives. This seems due to the effect of the pill on the binding capacity of transcortin and thyroxine binding globulin. There is no evidence of increased adrenal cortex or thyroid function.

Vascular Effects

Thrombophlebitis and pulmonary embalism

Two reports from England in 1968[2, 3] indicated a strong relationship between the use of oral contraceptives and thrombophlebitis and death from pulmonary embolism and other vascular accidents. The mortality from these complications among pill users was about seven times that among non-users. These risks, however, are extremely small and less significant than the risks of death from some everyday activities like automobile accidents. If one would compare the mortality from vascular accidents in women while using contraceptives to the mortality associated with pregnancies resulting from failure of other forms of contraception, it becomes apparent that pill users fare better.

To complicate the issue further, a recent report by Drill[4] showed no difference in incidence of thrombophlebitis between pill users and non-users. Another study carried out in Puerto Rico[5] failed to demonstrate any relationship between oral contraceptives and deaths due to vascular accidents.

Recent reports claim that the risk of thromboembolism is related to the amount of estrogen in the pill. It would appear that with the present low-estrogen preparations, the risk of thromboembolism might be insignificant. However, more data will be necessary to prove this.

Hypertension

Several well documented reports have indicated a small but definite increase in blood pressure among users of oral contraceptives. It has been demonstrated that the blood pressure of particular individuals can be reproducibly affected by the use of birth control pills. On the other hand, Goldzieher[1] was unable to demonstrate any significant change in blood pressure among pill users. In the Puerto Rico study, no significant increases in blood pressure were observed among pill users on serial followup.

It seems obvious that with the evidence at hand it is difficult to ascertain if there is a definite hypertensive effect of the oral contraceptives. However, according to the positive reports the blood pressure changes are reversible even after prolonged use of the pill. Thus, the problem can be safely circumvented by careful monitoring of blood pressure during use of oral contraceptives and prompt discontinuance of use should hypertension occur.

Carcinogenesis

The fear of cancer has obviously been foremost in the minds of pill users and physicians alike. The data regarding the relationship between cancer and oral contraceptives can be summarized as follows:

Breast

All currently used oral contraceptives have been tested in both monkeys and dogs and thus far none of the compounds has produced tumors in these two groups of animals. Two experimental estrogen–progestin combinations induced breast tumors in beagle dogs; however, limited biopsies showed these tumors to be benign. Furthermore, it has been argued that the increase in mammary tumors in the treated animals is not statistically significant. Also, the excessive dose of hormone used in these experiments has been questioned. Transfer of these animal data to the human would not be justified.

Although estrogen causes epithelial changes in the human breast, its carcinogenic effect on that organ has never been proved. In 1969 the Advisory Committee on Obstetrics and Gynecology[6] concluded in its report to the FDA that "lacking conclusive information about the applicability of existing animal data to women and sufficient direct observations in human studies, the Committee believes that potential carcinogenicity of the oral contraceptives can be neither affirmed nor excluded at this time."

Recent reports by Taylor,[7] Arthes,[8] and Vessey[9] have failed to demonstrate morphological changes in women's breasts related to oral contraceptives. The data provide no evidence that the administration of birth control pills is associated with the development of breast cancer.

Endometrium

Endometrial carcinoma is difficult to study in relation to etiologic causes. This is primarily due to the prolonged pathogenetic phase of the disease and to the lack of data on its incipient phases. From the data available no valid conclusions can be drawn about endometrial carcinoma and oral contraceptives.

Cervix

The possible relationship of oral contraceptives to cervical dysplasia and cancer has been under broad investigation. Although one study has shown an increased prevalence of carcinoma *in situ* of the cervix among pill users, the number of variables involved in that study precludes establishing that oral contraceptives have a carcinogenic effect.

Prospective studies have been urgently recommended by many authorities. One such study by Sandmire,[10] comparing users and non-users of oral contraceptives, failed to show any difference in the incidence of cervical cancer between the two groups.

Available data fail to establish a causal relationship between oral contraceptives and cancer of the cervix. If one accepts the concept that cervical cancer is a preventable disease, then the use of oral contraceptives would make that goal better attainable as periodic screening of pill users would detect dysplastic changes so that adequate therapy could be instituted.

Conclusion

It is the physician's responsibility to determine which contraceptive is most appropriate for a particular woman. If an oral contraceptive is the choice, the physician must inform the patient of the metabolic alterations and possible risks and complications discussed above.

Investigators continue to look for the ideal contraceptive agent. In the meantime the "pill" has become the most accepted contraceptive mainly because of its unquestioned effectiveness and absence of coitus association. As stated in the final conclusion of the Advisory Committee on Obstetrics and Gynecology,[5] "for many women oral contraceptives are undoubtedly the most effective method of fertility control currently available. It is evident that they exert many effects on many organs. The changes appear transient, however, and unlikely to pose serious hazards to health. Continued surveillance is nevertheless recommended."

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Guide to Clinical Pharmacology Programs

The first detailed guide to training programs in clinical pharmacology has just been published by Pfizer, Inc. The 105-page booklet, entitled "Clinical Pharmacology—A Guide to Training Programs," describes the 50 programs offered throughout the United States and Canada. Included are the clinical focus of each program, the facilities and training support available to the student, a listing of the faculty, a description of the school and application procedures. Copies of the booklet will be made available to medical schools for distribution to physicians interested in pursuing a career in clinical pharmacology. A limited number of copies also are available to physicians from the Pfizer Public Affairs Division, 235 East 42nd St., New York, NY 10017. □

The Impact of Radioimmunoassay for Hepatitis B Antigen on Blood Banking and Transfusion Practices in Wisconsin

GARY A. BECKER, MD, *Badger Red Cross Blood Center*, Madison, Wisconsin
RICHARD H. ASTER, MD, *Milwaukee Blood Center, Inc.*, Milwaukee, Wisconsin

In February 1973 the two major blood collection agencies in the State of Wisconsin, the Badger Regional Red Cross Blood Center and the Milwaukee Blood Center, began testing all blood donations for hepatitis virus B antigen by radioimmunoassay. This procedure is considerably more sensitive than the currently employed counterelectrophoresis method and, hopefully, will be a major step toward elimination of transfusion-related hepatitis. However, the time required to complete this test, 24 hours or longer depending upon the number of units processed, will have a profound effect on the operation of regional blood centers and on transfusion practices in the hospital.

To accommodate this procedure the regional blood center will have to increase its technical staff to provide for 24-hour, 7-day-a-week coverage. In many ways this effect is beneficial and should strengthen the total operation of regional blood suppliers. The most immediate effect of radioimmunoassay will be on the definition of fresh blood. If fresh whole blood is to be screened by radioimmunoassay it will be at least 24 hours old before it may be released. The number of viable platelets, the usual blood element for which fresh whole blood is given, will be nil in these units. Furthermore, regional blood centers will lose at least one and probably two days of shelf-life on all units of whole blood and packed cells as a result of this procedure. In order to meet rapidly increasing demands for cryoprecipitate and platelet concentrate, both of which must be harvested from whole blood within a few hours after donation, regional blood suppliers must fractionate most fresh blood into its various components. These may subsequently be stored for short or long periods until hepatitis testing is completed. Because of the increased "lag time" between blood donations and blood transfusion, regional blood centers will, in addition, need to increase the number of blood donations in order that shortage situations rarely, if ever, occur. Hopefully, this will obviate the need to release blood to hospitals screened only by counterelectrophoresis.

The major impact of radioimmunoassay, however, will be on the transfusion practices of physicians in the community. Fresh whole blood will no longer be available. In fact, *whole* blood of any age will be available only in limited quantities. Since packed red blood cells are the byproduct of all component preparation, this product must be used for the majority of transfusions. If volume expansion, platelets or coagulation factors are required, they must be provided by transfusing the appropriate component. Furthermore, when transfusing patients with rare blood types, it frequently may be necessary to use a second choice. By this is meant giving A positive packed cells to an AB positive recipient, A negative packed cells to an AB negative recipient, using more group O positive packed cells for transfusion needs, and the like. The burden of proof will be placed on the practicing physician if he approves transfusion of whole blood not screened by radioimmunoassay when an alternative, completely screened product, is available. Of course, when clinical situations arise in which it is absolutely necessary to transfuse blood within a short time after donation, patients must not be deprived of this material. These situations should be evaluated by the attending physician, hospital blood bank, and regional blood center.

Finally, the fact that the two major blood suppliers in the state are utilizing radioimmunoassay for hepatitis testing may require all smaller blood banks, both hospital and community, to do the same. This does not apply to the Milwaukee area where hospitals do not draw donors. However, in the Badger regional system, hospitals distant from the Madison Center occasionally draw donors. It is to be hoped that with increased blood supply and improved service, drawing donors at hospitals will be a rare occurrence.

Regional blood centers and hospital blood banks have been promoting blood component therapy for years. Hopefully, the new technology will speed universal acceptance of this concept.

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Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

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Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 5 MAY 1973

FROM THE PRESIDENT

"Let Joe Do It"

Your organization needs you. You must assert and reassert wherever possible the positive aspects of organizational ideas and strengths. Are you knowledgeable about our programs so that you can be spokesman relating to legislative programs and our plans to better the health of our citizens?

We support programs to better protect the health and welfare of your patients relating to quality control of care, reformation of the care of the alcoholic and mentally ill, broad education of our citizens relating to health matters, insurance for the unemployed and uninsured, support for catastrophic protection, legislation in support of physician assistants, and increased enrollment in our medical schools. Endless are our programs to better your education through continuing medical education programs and ongoing study of maternal and child welfare. Your commitment must be sincere and promoted.

In my inaugural address I recommended a new system of ombudsmanship to hear patient complaints as well as a Wisconsin Health Corps to serve the areas of medical need through a voluntary plan. You were encouraged to lead in the areas of PSRO and promotion of Medicredit.

You must be knowledgeable and outward oriented to increase our credibility in the eyes of the public and the legislators. Wisconsin medicine has not been good in our public relations efforts in the past. Only with your help on the home front will our lobbyists be successful. This is the "Political Year." Have you communicated with your legislator, or does "Joe" do it for you? Joe has failed in the past!!

G. J. Derus M.D.

STAT

Pulling All Stops

Memorial Day weekend is always one of the bloodiest times of the year in Wisconsin. Each year a number of grinding auto accidents take their toll of travelers celebrating the long holiday. This year Governor Lucey is pulling all the stops to change this pattern in fatality-ridden Chippewa and Kenosha Counties. Planners in the highway safety department are pouring over computer print outs on past accidents to pinpoint areas that need special police surveillance. Every available squad car will be on the road and National Guard and Civil Air Patrol teams will help with such duties as clearing up traffic congestion and helping disabled motorists. Physicians in the two counties are making sure that medical help is never more than a phone call away. If the plan works, the morning after this Memorial Day weekend may be less painful than last year.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Mr. McMahan

Dr. Smith

Assistant Treasurers

Assistant treasurers reelected at the State Medical Society's Annual Meeting in March were Drs. H. Kent Tenney and A. A. Quisling (State Medical Society), John T. Sprague (WPS–Blue Shield), and Nels A. Hill (SMS Realty Corporation), all of Madison. Dr. Max M. Smith, Madison, was elected assistant treasurer for WPS–Blue Shield to succeed Dr. R. A. Sievert, Madison. April GREEN SHEET information on these elections was incomplete.

Governor's Appointee

Osteopathic leader, Thomas Knowlton, DO, Beaver Dam, succeeds Ray R. Rueckert, MD, Portage, to the Council on Health. With this appointment by the Governor, the Council's composition is three MDs, two DOs, a dentist and one non-medical appointee.

Dr. Knowlton is the past president of the District and State Associations of Osteopathic Physicians and Surgeons and serves on the staff of the Beaver Dam Community Hospitals.

Council members have staggered seven-year terms. The Council is an advisory group within the State Department of Health and Social Services.

Health Insurance, China

A Forum on Medical Affairs, Sunday morning, June 24, during the AMA Annual Meeting, will feature speakers on China's health-care system and health insurance.

Speakers for the half-day meeting are: John A. McMahon, President of the American Hospital Association; Leslie D. Hemry, President of the Health Insurance Association of America; the Honorable Joe D. Waggonner (D–La), a member of the House Ways and Means Committee; and Edmund C. Casey, MD, President of the National Medical Association.

Dr. Casey recently returned from China and will tell about the health-care delivery system there. The Forum is open to all at the AMA Annual Meeting.

Opening speaker will be the President-Elect of the Conference of State Presidents and Officers, Ralph C. Teall, MD, California.

Dr. Tenney

Dr. Sprague

Dr. Hill

Dr. Quisling

Final Tallys

With the final tallys in on the State Medical Society's Annual Meeting in March, it appears physicians liked holding all scientific meetings in two days.

Total physician attendance, 991, was up 49 over last year's three-day session. Total attendance was 1,647, including 150 interns–residents–medical students, 283 exhibit representatives, and 223 guests (nurses, physicians' wives, etc.).

Tallys for registration at the three sessions of the House of Delegates were: 123 first session, 122 second session, and 110 third session. There are 143 voting members of the House.

Dates for next year's Annual Meeting are March 24–26 for the House of Delegates and March 25–26 for scientific sessions. □

MUSEUM

Fat, Skinny, Short

The development of a baby before birth, how our ears hear, how our glands can make us fat, skinny, short or tall—these are subjects of some of the new exhibits at the Museum of Medical Progress in Prairie du Chien this year.

The Museum opened April 15. It has educational and historical exhibits on frontier and Indian medicine as well as light-up and talking exhibits on current health topics.

How life begins is shown by 12 fetuses varying in development from four weeks to full term. Charts show the earliest cell divisions at conception. Three-dimensional models show six stages in the birth of a baby. The exhibit is one of several on loan from the American Medical Association.

Another explains how we hear, why people become deaf, and explains some common ear conditions. A third shows the location of glands in the body and uses large models to show how they work and what they do.

Located on the site of the historic Fort Crawford on the Mississippi River, the Museum is a registered national historic landmark. It is operated by the State Medical Society's Charitable, Educational and Scientific Foundation.

Museum hours are 8 AM to 5 PM daily through Oct. 31. □

Museum visitors view exhibit on development and birth of a baby.

LAW

Is Brown County Medicine Unique?

How unique is the practice of medicine in Brown County? It shouldn't be unique at all, but should be very much like the medicine that is practiced throughout the country.

That was the opinion of the State Supreme Court in an April 20 ruling. From now on, the court said, the work of a physician anywhere in the state should be about like that of his colleagues anywhere else.

The landmark ruling came in a suit against a Brown County physician. Although the physician was absolved of blame, the high court used the case to scuttle a long-standing test for medical professional liability.

For over 80 years Wisconsin physicians have been expected to use the same care, judgment, and skill as their colleagues "in the same or similar localities." From now on, the court said, a practitioner is liable for negligence "if he fails to exercise that degree of care and skill which is exercised by the average practitioner in the class to which he belongs, acting in the same or similar circumstances."

The court relied heavily on two Washington Supreme Court cases which said, in effect, times have changed. In the old days a "locality rule" was needed because of limited travel and access to medical literature. Then, physicians in small communities did not have the same professional opportunities and resources as did doctors practicing in large cities.

Today, the court said, the trend is toward a nationwide standard. Physicians across the country are kept informed by the same journals and all have access to drug company "detail men," postgraduate courses, and special medical presentations recorded on tape and broadcast on radio and television.

The Wisconsin court qualified this only slightly by saying that "geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate." □

Freedom of Information

A new "freedom of information" in government records now affects claims and other benefit programs. In particular, the Bureau of Social Security Disability Insurance can release medical information contained in disability claims to insurance companies, attorneys, and others with a valid need for it.

In most cases this means information the Bureau purchased from medical consultants is available if both physician and patient agree to its release. The Bureau often pays medical consultants for special exams on people claiming to be totally disabled and thus qualified for Social Security benefits. Under the new rules, the consultant's report can be used for legitimate non-Social Security purposes when physician and patient are agreeable.

However, in most cases the Bureau's reports from the treating physician and other sources still will not be released. Such requests will continue to be referred to the physician supplying the information. Exceptions would be in cases where the treating physician is no longer living or his records have been destroyed.

Direct questions to Henry A. Anderson, MD, at the Bureau, 310 Price Place, Madison. □

Medical Unit Seeks Shift Of Emergency Care Study

By DAN PATRINOS

The Wisconsin Regional Medical Program (WRMP), a casualty of President Nixon's budget cuts, has proposed transferring its federally funded study of state emergency medical services to the Wisconsin Hospital Association.

The study, aimed at assembling a co-ordinated system, has been guaranteed $1.2 million for two years, but on Dec. 31 WRMP will be disbanded unless Congress decides otherwise.

The hospital association, which is now a subcontractor for administrative aspects of the study, would become the prime contractor after Dec. 31. Another proposal being studied would reconstitute WRMP into a corporation with state government representation.

Under whose auspices the study will eventually end up will be decided by the US Department of Health, Education and Welfare for Congress, if the latter has enough votes to override Nixon's promised veto of legislation to keep the Regional Medical Programs throughout the country alive.

Funds in Doubt

The study is planned to take three years. Where the money would come from after 1974 is still another question to be answered. The study's budget calls for $693,440 in the third year.

More than 30 large organizations, including both of the state's medical schools, are involved in the study.

The plan is to complete a statewide radio communications system that would interconnect ambulances, dispatchers, hospitals and other medical services, so that an ambulance attendant could be in constant contact with skilled medical advisers from the scene of an accident until the time he arrives at the hospital with the patient.

BACKGROUND OF THE NEWS

To Rate Hospitals

Another effort is to develop emergency vehicles to meet emergency needs in urban areas. Hospital capabilities will also be assessed.

"If you cut your hand with a butcher knife, almost any hospital has somebody that can sew you up," a doctor said. "But if you're in an automobile accident and your liver is fractured, your heart is bruised, your chest is leaking air and you are in profound shock, you don't want the nearest hospital. You want the best."

WRMP is a private, nonprofit organization located in Milwaukee. It is headed by Dr. John S. Hirschboeck, former dean of the Marquette University School of Medicine. The group was started in 1966 to improve health care in the state.

11 Projects Involved

The end of WRMP would mean the end of its 11 current projects, excluding the emergency medical services study, by June 30.

Here is a list of some of the current projects, their cost and what has been accomplished:

- A kidney project, which has been in operation since 1970 at a cost of $600,000 a year, would be terminated about two months earlier than planned. About 20% of the money was spent to set up a home dialysis training program for patients.

With project money, University of Wisconsin — Madison physicians taught nurses how to reduce infection in kidney patients who use catheters, and trained surgeons how to remove kidneys from cadavers for use in transplants.

In Milwaukee the Medical College of Wisconsin used funds to help develop a computerized system of keeping track of potential kidney transplant patients. The Milwaukee Blood Center was helped in setting up a tissue typing service used in matching donor kidneys to recipients.

- A nurse-pediatrician team project was started last July and was to run until July, 1975, at a cost of about $82,500 a year. Sixty-four teams have been trained, in Milwaukee and Madison, so that a nurse can do some of the things a baby doctor has traditionally done. These include advising mothers on milk formulas, giving baby examinations and advising parents on childhood illnesses.

Most of the nurses have undergone the one month training program at the University of Wisconsin — Madison and affiliated hospitals. Most of them come from the offices of rural physicians. Recently, the program was started at Milwaukee Children's Hospital.

Projects compete

Hirschboeck said WRMP was seeking money from private foundations to continue the project, but was finding competition from projects sponsored by the Office of Economic Opportunity — another Nixon casualty.

- A nurse coronary care training project at the University of Wisconsin — Milwaukee has a waiting list for its four week course. The Veterans Administration Hospital is collaborating in the program to insure that it has a source of nurses to staff its coronary care unit.

Started in 1971, the project was to end next year and receive about $30,000 annually. More than 100 nurses from throughout Wisconsin have been trained.

- WRMP has funded the 16th Street Neighborhood Health Center since September, 1971, and was to continue supporting it with $55,000 annually for a total of three years. The center is in a Spanish-speaking neighborhood.

The center offers classes in nutrition, venereal disease prevention, child care and family planning. Clinic workers also seek out people who need health care and refer them to health agencies.

The center has not been success from the standpoint WRMP evaluators. The cent employs people from t neighbor who are usually we received, socially cultural and linguistically the neig bors they are seeking to hel but these worker do not a ways have the skill needed health matters.

Frequently, young worke at these clinics bring more e thusiasm than expertise an often become involved more community organizing and po itics rather than in health pro lems, WRMP evaluators ha reported.

- Wisconsin Health Care R view (WHCR), a corporatio designed to monitor the qua ty of care provided by doctor dentists and hospitals, bega receiving money in Januar The first year's budget call for $80,000. WRMP's fundi was to continue for thre years.

WHCR was formed by orga nized health groups in th state in an attempt to keep e pected government monitori in private hands.

- In the St. Croix Valley, hospitals have formed a corpo ration to show how the instit tions can share services an thus eliminate the necessity o ech employing people to do th same thing.

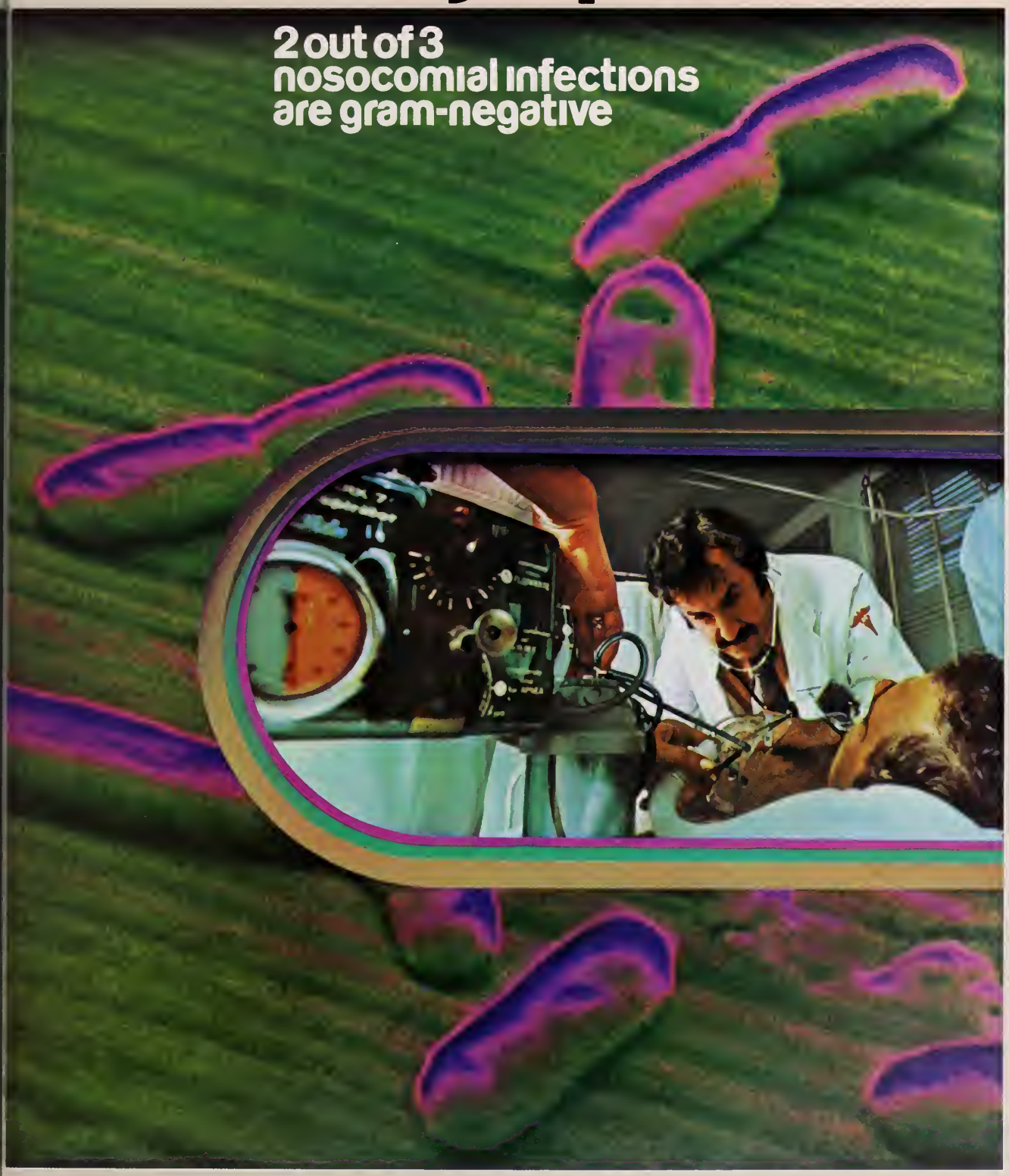
The one year project, starte last December with a grant o $25,950, is attempting to dem onstrate that each hospita doesn't need a dietitian, lau dry facilities, a pathology lab ratory, a radiology section or physical therapy departmen more

- In the La Crosse area se en hospitals, excluding the tw hospitals in the city of L Crosse, have been budgeted t receive $32,600 for a one yea study to demonstrate the sam thing.

- In Cudahy, Trinity Memo rial Hospital last December be gan receiving money from $30,822 grant to show that patient does not have to b hospitalized for certain test So often, patients are admitte to hospitals for tests that coul be done on an outpatient basi When this testing is done i the hospital the already hig cost of hospital care goes eve higher.

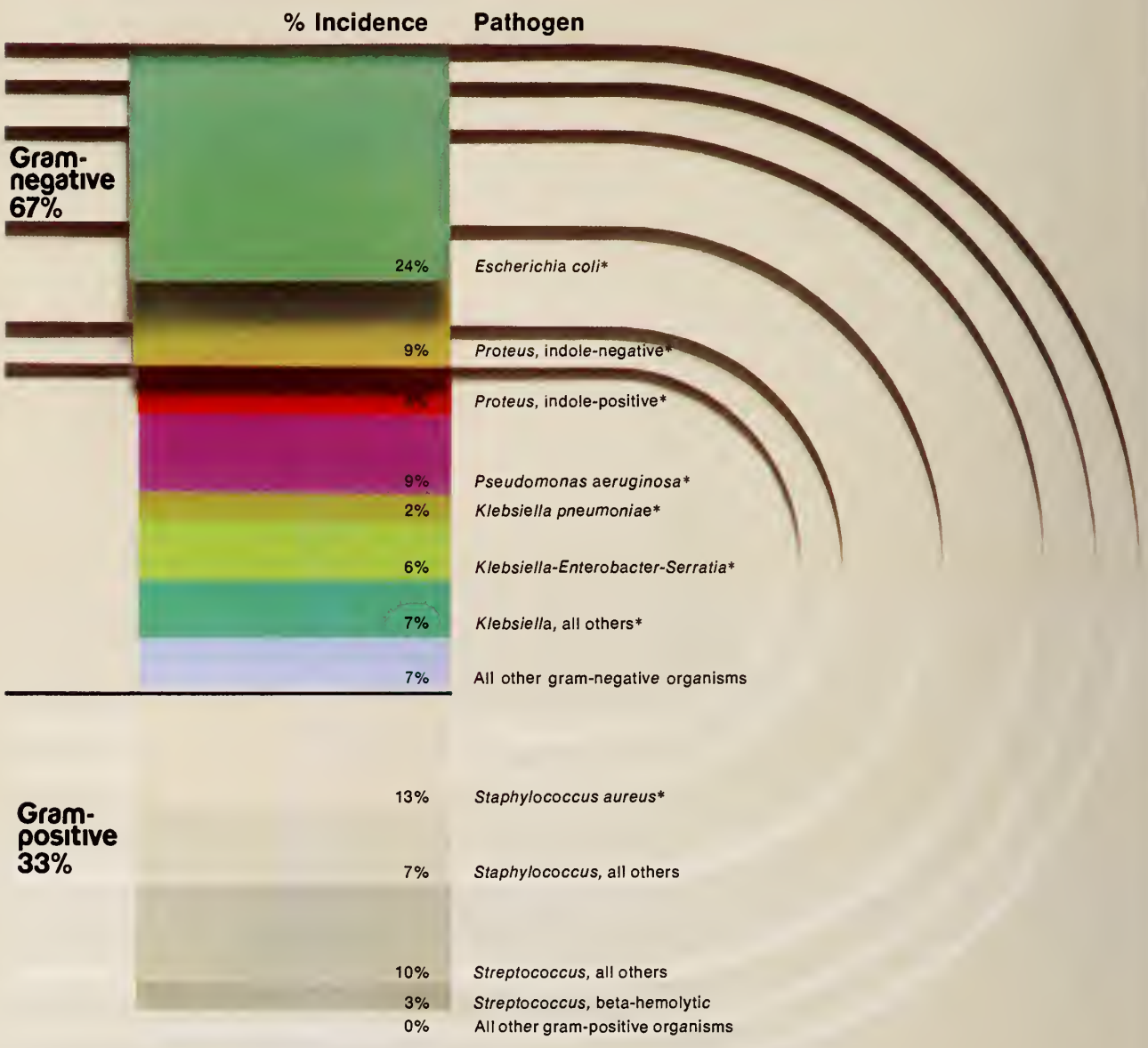
Schering

On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

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Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
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GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

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Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

*Due to susceptible organisms

SLR-301

NEWS HIGHLIGHTS

Wisconsin Urological Society Met in April

On April 13–14 the Wisconsin Urological Society met at the Pfister Hotel in Milwaukee. President Richard Troup, MD* of Green Bay presided. A large number of members were present to hear a varied selection of urological papers. Besides the members and residents in the urological program in Wisconsin, the following guest speakers participated: Dr. John P. Donohue, chairman of the Department of Urology, University of Indiana Medical School; Dr. Douglas W. Voth, associate professor of medicine, University of Kansas Medical School; Dr. Philip Veenhuis from the Division of Human Behavior, Medical College of Wisconsin, Milwaukee; and Dr. Harry F. Weisberg,* director of the Division of Biochemistry, Mt. Sinai Medical Center in Milwaukee.

During the business session, Paul O. Madsen, MD* of Madison was elected president for 1973–1974. Robert A. Wood, MD* of Sheboygan is the president-elect and John D. Silbar, MD* of Milwaukee is secretary–treasurer.

Section on Anesthesiology Names Chairman

At the March 27 meeting of the State Medical Society's Section on Anesthesiology, William H. Nicolaus, MD* of Green Bay was named chairman of the Section. Ruth A. Stoerker, MD* of Madison was named secretary. Reappointed delegate and alternate delegate, respectively, were Robert E. Holzgrafe, MD* of Waukesha and John W. Temple, MD* of Wauwatosa. They will serve until the fall meeting of the Section in September 1973.

New Medical Clinic Facility for Rice Lake

Plans have been announced for the construction of a new medical clinic facility in Rice Lake. It will accommodate up to 10 physicians in a central location adjacent to Lakeside Hospital. The new clinic will be owned and operated by the Indianhead Medical Group, a merger of the two present clinics in the city, the Rice Lake Clinic and the Indianhead Medical Clinic. Participating physicians include: Doctors W. B. Rydell,* J. K. Hoyer,* James Maser,* Lloyd R. Cotts,* L. A. Kristensen,* and John T. Henningsen.* Dr. O. E. Rydell,* also presently associated with the Rice Lake Clinic, has announced his intention of retiring from active practice. The group will be joined in July by Dr. Lester Thompson of Denver, Colo. The $350,000 building is expected to be completed in late 1973.

Wisconsin Heart Grants Funds to Marshfield Clinic Foundation

The Marshfield Clinic Foundation for Medical Research and Education has been awarded grants totaling $21,789 from the Wisconsin Heart Association, according to Frederick J. Wenzel, executive director of the Foundation.

A grant of $9,291 was made to Edward D. Plotka, PhD to support his research on the relationships between cholesterol and blood platelets and their possible role in the development of coronary artery disease. Jefferson F. Ray, MD* received a $5,232 grant to study whether the infusion of the heart's circulation with a solution of glucose, insulin and potassium can increase the viability of the heart muscle after open heart surgery. A $7,266 award was made to Duane A. Tewksbury, PhD to continue his study on the role of the kidney and its control of blood pressure.

PHYSICIAN BRIEFS

John B. Wear, Jr., MD*

. . . Madison, recently was the guest speaker at the University Hospitals Volunteer Appreciation Luncheon. Doctor Wear, who spent two months on the hospital ship S.S. HOPE, worked in the port of Natal, Brazil.

Lou R. Schmidt, MD*

. . . recently became associated with the staff of the Sparta Clinic. Doctor Schmidt has been associated with St. Francis Hospital, La Crosse, since 1947 and also headed the Student Health Service at the University of Wisconsin–La Crosse until his resignation in March.

Oscar A. Farias, MD*

. . . Superior, recently entered part-time practice at the Giesen Clinic. He is medical director of the admissions unit of the Douglas County Hospital at Parkland and medical director of the Middle River Health and Extended Care Facilities. He also is associated with the Douglas County Guidance Center. Doctor Farias has been practicing in Douglas County for the past ten years.

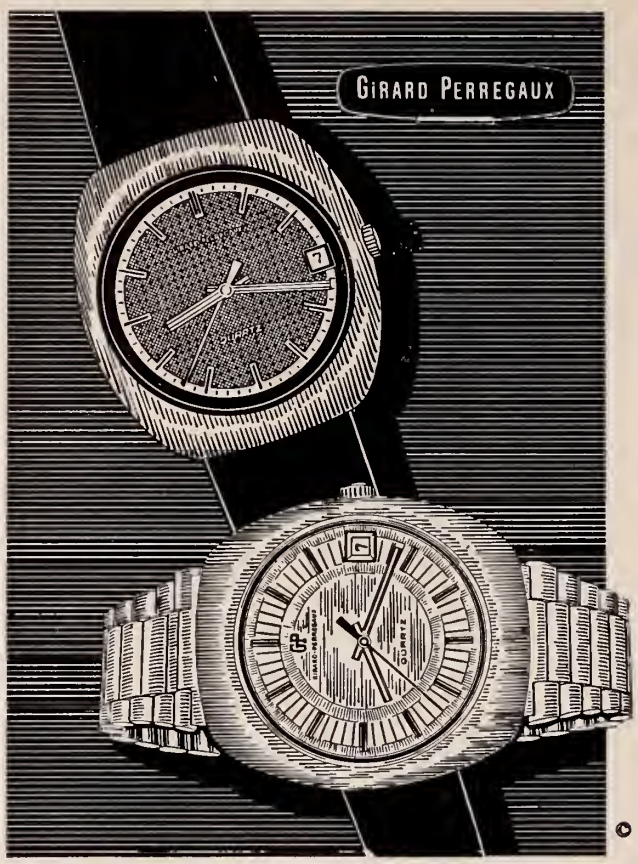
Roger I. Bender, MD*

. . . Beaver Dam, recently attended the 14th annual Clinical Congress of Abdominal Surgeons in Honolulu, Hawaii.

John H. Renner, MD*

. . . director of the Family Practice Program of the University of Wisconsin Medical School, Madison, spoke on "Patient Education in the Rural Physician's Office" at the AMA National Conference on Rural Health in Dallas, Tex., March 30. Dale E. Treleven, research director at Family Practice, spoke at the conference on "A Procedure for Conducting Rural Health Manpower Research."

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



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PHYSICIAN BRIEFS . . .

Thomas F. Beckner, III, MD*

. . . La Crosse, recently became associated with C. Norman Shealy MD,* in the Pain Rehabilitation Center at St. Francis Hospital, La Crosse. He graduated from the University of Tennessee Medical School and served his internship at City of Memphis Hospital in Tennessee. Doctor Beckner will be responsible for the medical aspects of the program.

William L. Harlan, MD*

. . . Monroe, recently joined the Department of Neurology of The Monroe Clinic. Doctor Harlan graduated from the Indiana University Medical School and served his internship at Grace Hospital in Detroit. He spent two years in the Department of Neuropsychiatry at Bethesda Naval Hospital, Md., and at a naval hospital in San Diego. From 1954–1957 he was a fellow in neurology at the Mayo Clinic, followed by two years as assistant professor of neurology at the University of Texas, Galveston. Doctor Harlan was in private practice for ten years at Evansville, Ind., and then became associate professor of neurology and associate professor of preventative medicine at Creighton University, Omaha, Neb.

Anthony R. Curreri, MD*

. . . Madison, chairman of the Department of Surgery for University Hospitals, Madison, recently was nominated for a four-year term as regent of a planned University of Health Sciences for the Armed Forces.

Richard B. Bourne, MD*

. . . Milwaukee, recently was appointed chairman of the Medical Advisory Committee of the Planned Parenthood Association of Wisconsin. Doctor Bourne, who also is on the association's board of directors, is an assistant clinical professor of urology at the Medical College of Wisconsin and acting chief of urology at the VA Hospital, Wood.

Wisconsin Surgical Society Has March Program

About 150 members of the Wisconsin Surgical Society participated in the all-day meeting of the Society March 27 during the Annual Meeting of the State Medical Society of Wisconsin in Milwaukee. The morning program was held at the Milwaukee County General Hospital as a Wet Clinic presented by the Division of Surgery, Medical College of Wisconsin. Robert E. Condon, MD* was in charge of activities.

The Society's business meeting was held in the hospital followed by a luncheon. The afternoon scientific program was held at the Pfister Hotel and the evening banquet was at the Milwaukee Athletic Club. About 85 members attended the morning session, approximately 200 attended the afternoon session, and 150 were at the banquet.

New officers of the Wisconsin Surgical Society for March 1973–1974 are: president, Wilson Weisel, MD,* Milwaukee; past president, Wayne J. Boulanger, MD,* Milwaukee; president-elect, Louis D. Graber, MD,* Oshkosh; secretary–treasurer, P. Richard Sholl, MD,* Janesville; and recorder, Gale L. Mendeloff, MD,* Milwaukee.

Council members are: Leonard W. Worman, MD* (1974), Milwaukee; Edward I. Boldon, MD* (1974), Madison; George F. Pratt, MD* (1975), Rhinelander; Bruce J. Stoehr, MD* (1975), Green Bay; Marvin Wagner, MD* (1976), Milwaukee; and Gail H. Williams, MD* (1976), Marshfield. Expiration of terms is shown in parentheses; the latter two doctors are new members.

Milwaukee Medical Society Has Battle Plan for VD

The Medical Society of Milwaukee County in cooperation with the City of Milwaukee Health Department and the State Division of Health has developed a community-wide battle plan for Milwaukee County which would coordinate efforts in public education, testing, and treatment of venereal disease.

Development of the coordinated effort came about as the result of the Medical Society's establishment of a community Task Force on Venereal Disease Education and the availability of federal funds as part of a nationwide venereal disease control effort.

Jules D. Levin, MD,* president of the Medical Society, has stated that there is a serious health situation in Milwaukee County, with an alarming increase in the incidence of venereal disease. Mark Popp, MD* heads the Task Force which will play a significant role in the attack on VD.

"As a result of the federal funds, laboratory services are now available to private physicians enabling them to perform routine gonorrhea culturing without having to charge the patient for laboratory services," Dr. Popp said. More than 5,000 cultures are now being performed each month. The positivity rate on a random sample basis is now running 4.7% at the City of Milwaukee Health Department Lab where many of the tests are processed.

Physicians are being encouraged to routinely perform gonorrhea cultures on all of their female patients as a part of the patients' regular yearly physical examination.

Organizations now represented on the Task Force include: The Medical College of Wisconsin, Hospital Council of Greater Milwaukee, Milwaukee District Nurses Association, Milwaukee Pharmacists' Society, Woman's Auxiliary to the Medical Society of Milwaukee County, Planned Parenthood, Milwaukee Urban League, Milwaukee and Wisconsin Jaycees, United Migrant Opportunity Workers, and the Milwaukee Public School System.

Dr. Nadeau

Dr. Pearson

Emile G. Nadeau, MD*

. . . Green Bay, recently was presented with the Paul Harris Fellow Award from the Green Bay Rotary Club. Doctor Nadeau, who is 81 and still in full practice with his son, George Nadeau, MD,* travels monthly to meetings of the Chicago Ophthalmological Society which he joined in 1914. In honor of his accomplishments in medicine and society, of his partiality for world travel, and of his 49 years as a rotarian, the Club announced it has donated $1,000 to the Rotary International Foundation in Doctor Nadeau's name. Doctor Nadeau was the first chief-of-staff at St. Vincent Hospital in Green Bay and also was partly responsible for the hospital's first accreditation by the Joint Commission on Accreditation of Hospitals. He is a pioneer member of the American Academy of Ophthalmology and Otolaryngology and has watched the organization grow from 800 to 10,000 members. In Wisconsin, he organized the State Medical Society's sections on the two specialties.

Carlyle R. Pearson, MD*

. . . Baraboo, recently was awarded the Baraboo Jaycee Distinguished Service Award. In conjunction with the award, the St. Clare Hospital of Baraboo also declared March 16 as "Dr. Carlyle R. Pearson Day." Doctor Pearson was honored for his more than 35 years of outstanding contributions to medical care.

SCIENTIFIC EXHIBIT AWARDS

1973 Annual Meeting
STATE MEDICAL SOCIETY OF WISCONSIN

March 25–27—Milwaukee
Pfister Hotel

Special Merit Awards

Division for Handicapped Children, Bureau for Crippled Children, Department of Public Instruction, State of Wisconsin, Madison

S-4
Prevent Deformity—Detect Scoliosis Early: Scoliosis Posture Screening Program

* * *

Medical College of Wisconsin and Milwaukee County General Hospital, Department of Radiology, Milwaukee

S-14
Xeromammography
JOHN R. MILBRATH, MD and TONY DEETHS, MD

* * *

Medical College of Wisconsin, Milwaukee

1
Children's Elbow Fracture: Game Plan
T. J. FLATLEY, MD; B. J. BREWER, MD; and M. C. KUBLY, MD

* * *

University Hospitals, Department of Medicine, Madison

51
A Computer-based System to Simulate the Patient–Physician Encounter
RICHARD B. FRIEDMAN, MD

WINNERS OF RESIDENT–INTERN PAPERS PROGRAM

W. S. Middleton Award

Tibial Resonant Frequency Measurements as an Index of the Strength of Fracture Union
E. LAWRENCE MARKEY, MD
Resident, University Hospitals
Madison

Harry Beckman Award

Rapid Diagnosis of Hepatic Disease by Determination of Serum Liver Lactic Dehydrogenase
LAWRENCE E. NATHAN, JR., DO
Resident, University Hospitals
Madison

NEWS HIGHLIGHTS . . .

Neurological Society's Spring Meeting Set June 1–2

The Spring Meeting of the Wisconsin Neurological Society will be held at the Wisconsin Center in Madison on June 1 and 2. It will be an open meeting with no registration fee. The program will include a get together party from 7:30–9:00 p.m. on Friday, June 1. Saturday, June 2, the scientific session will include the following speakers: 9:00 a.m.—Dr. S. W. Boyer,* *The Syndrome of Transient Global Amnesia;* 9:30 a.m.—Dr. P. G. Gottschalk,* *Normal Pressure Hydrocephalus Occurring with Basilar Impression Due to Paget's Disease of the Skull;* 10:00 a.m.—Special Guest Lecturer, Dr. C. H. Millikan, *The Diagnosis and Management of Various Types of Carotid System Occlusive Disease;* 11:30 a.m.—Intermission for lunch; 1:00 p.m.—Drs. J. L. Bender, J. H. Van Landingham and N. J. Manno, *Thoracic Epidural Lipoma Producing Spinal Cord Compression;* 1:30 p.m.—Drs. C. E. Miley and F. M. Forster,* *Paroxysmal Neurological Symptoms in Two Patients with Multiple Sclerosis;* 2:00 p.m.—Dr. P. G. Gottschalk,* *Acute Necrotizing Myelopathy Associated with Carcinoma of the Breast;* 2:30 p.m.—Drs. N. V. B. Manyam and E. Bravo-Fernandez, *Effect of Haloperidol and Lithium Carbonate in Huntington's Chorea;* 3:00 p.m.—Drs. S. A. Barron and H. E. Booker, *Celontin Metabolism in Man;* 3:30 p.m.—Business Meeting; 7:30 p.m.—Wisconsin Neurological Society Banquet.

Otolaryngology Groups Met in Milwaukee

The Wisconsin Otolaryngologic Society and the Section on Otolaryngology of the State Medical Society of Wisconsin held a meeting in Milwaukee during the State Medical Society's Annual Meeting, March 25–27. The following positions were approved: John M. Mills, MD,* Green Bay, president; Willis G. McMillan, MD,* Madison, secretary–treasurer; Thomas W. Grossman, MD,* Milwaukee, delegate to the State Medical Society; Donald J. Chrzan, MD,* Milwaukee, alternate delegate; and Donald S. Blatnik, MD,* Wauwatosa, representative of the Section on Otolaryngology to the Commission on Public Policy of the State Medical Society.

Two Dodgeville Hospitals Planning Merger

Extensive discussions between the directors of the two Dodgeville hospitals—General and St. Joseph's—and the Health Committee of the Iowa County Board of Supervisors have culminated in a merger proposal which would provide that the Iowa County Board take over both facilities and set up a corporation to operate them. Under the merger proposal St. Joseph's would be used as the single acute care facility or hospital and General's facilities would be used for nursing home care.

Symposium on Anesthesia and the Kidney Held

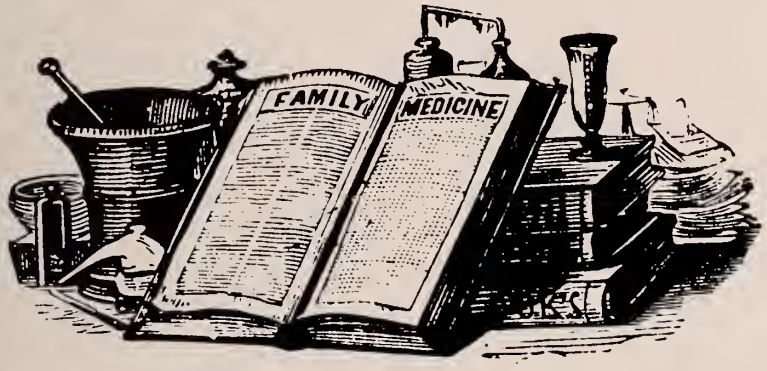
The Adolf Gundersen Medical Foundation's Third Annual Anesthesia Symposium was held April 28 in La Crosse. Nurse anesthetists and doctors from the tri-state area were in attendance. The main speaker was Stanley Deutsch, PhD, MD, professor and chairman of the Department of Anesthesiology, University of Oklahoma, Oklahoma City. Wisconsin speakers were: Robert O. Burns, MD, Department of Internal Medicine, Associated Physicians, Madison; and Gundersen Clinic MDs: Dr. William Kisken,* kidney transplant specialist, Department of Surgery; Dr. Wilfrido Yutuc,* Department of Internal Medicine; and Dr. Edwin Overholt,* director of medical education and research. Moderator of this year's seminar was David E. Goodnough, MD,* chairman of the Department of Anesthesia at Gundersen Clinic. Program chairman was John G. Jaeger, MD, also of the Department of Anesthesiology, Gundersen Clinic. □

William F. Schorr, MD*

. . . president of the Marshfield Clinic Foundation for Medical Research and Education, was guest speaker at the Society of Cosmetic Chemists at its annual seminar May 4 at the Netherlands Hilton Hotel in Cincinnati, Ohio. He discussed "Cosmetic Allergy—A Problem and Possible Solutions."

Robert A. Bonebrake, MD*

. . . Madison, recently was elected chairman of the Southern District, Arthritis Foundation of Wisconsin at its annual meeting. Andrew A. McBeath, MD,* Madison was elected vice-chairman and MDs Mark N. Mueller, Madison, and William Austad,* Monroe, were elected directors. □



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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1973

3	Dane County Medical Society Board of Trustees
3	Dane County Medical Society Public Health Advisory Committee
3	Dane County Medical Society Public Relations Committee
3	Madison Urological Society
3	Madison Anesthesiology Society
4	SMS Ad Hoc Committee on Chiropractic
5	Preceptors and Faculty, UW Medical School
6	Medical Advisory Committee, Wisconsin Emergency Medical Services Program
10	National Board Exams, Senior Students of UW Medical School
11	State Medical Examining Board
11	National Board Exams, Senior Students of UW Medical School
12	State Medical Examining Board (Reciprocity Exams)
12	Faculty and Junior Students, UW Medical School
16	Madison Orthopedic Society
18	Wisconsin Regional Medical Program
19	Executive Committee. SMS Commission on Medical Care Plans
19	MEDIHC Operating Committee
26	SMS Committee on Peer Review
26	SMS Commission on Scientific Medicine
26	Subcommittee of SMS Division on Maternal and Child Welfare

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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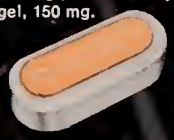

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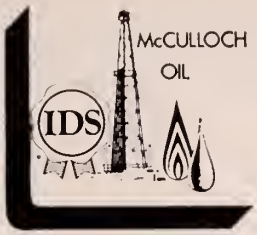

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OBITUARIES

Harry R. Foerster, MD, 83, professor emeritus of dermatology of Marquette University School of Medicine, died Feb. 20, 1973 in Milwaukee.

Born Sept. 1, 1889 in Milwaukee, Doctor Foerster received his medical degree from the University of Pennsylvania in 1914 and served his internship at Pennsylvania Hospital in Philadelphia. His residency was taken at Vanderbilt Clinic of Columbia University. Doctor Foerster had been on the faculty of Marquette University School of Medicine since 1921 and was chairman of the department of dermatology from 1951 until 1958 when he was named emeritus professor. From 1927 until 1944, he also was an assistant professor of dermatology at the University of Wisconsin in Madison. He was active in the private practice of dermatology until 1966 when illness forced his retirement.

During World War I, he served in France with the American Expeditionary Force as a captain in the U.S. Army Medical Corps stationed with Base Hospital No. 22, a Milwaukee-staffed medical unit. He was awarded the Selective Service Medal for his civilian services during World War II.

Doctor Foerster was a senior consultant in charge of postgraduate training in dermatology at the Veterans Administration Hospital in Milwaukee and was also on the medical staffs of Columbia, Lutheran, Milwaukee Children's and County General hospitals.

His memberships included the Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, American Academy of Dermatology, Wisconsin Dermatological Society, Chicago Dermatological Society, Society of Investigative Dermatology, Milwaukee Academy of Medicine, and Milwaukee Surgical Society.

He was past president, trustee, and director of the Milwaukee Academy of Medicine and a founder and past president of the American Academy of Dermatology. He also was past secretary and president of the American Dermatological Association. He had served as chairman of the Section of Dermatology for the American Medical Association and as president of the Medical Society of Milwaukee County. In 1949 he was elected an honorary member of the Royal Society of Medicine, Section of Dermatology, at London, England.

Surviving are his widow, Katherine; and two sons, Dr. Harry R. Jr. of Milwaukee, and Richard D., Tucson, Ariz.

Richard W. Way, MD, 51, Beaver Dam, died Feb. 25, 1973 in Beaver Dam.

Born on Aug. 12, 1921 in Madison, Doctor Way graduated from the University of Wisconsin Medical School in 1949 and served his internship at St. Francis Hospital, La Crosse. His residency was taken at Mercy Hospital, Iowa City, Ia. He was an attending surgeon at Beaver Dam Community Hospital.

He was a member of the Dodge County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

new Santyl™ ointment (collagenase)

Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

How Supplied: Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.

Knoll Pharmaceutical Co.
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new Santyl™ ointment (collagenase)

"...it may prove to be the drug of choice for wound debridement."

Varma A O *et al*: *Surg. Gynec. Obstet.* 136:281, Feb. 1973.

To permit healing like this...you want to start like this.

Artist's conception of decubitus ulcer

Santyl™ (collagenase) for dermal ulcers and burns: the first topical enzyme

▸ to attack
native collagen, a substance that is ordinarily resistant to all common topical enzymes used in wound debridement

▸ to dissolve
the strands of tissue that "anchor" necrotic debris and burn eschar to the wound surface

▸ to effectively remove
the debris that hinders healing...with simple, once-a-day application

I treat patients with dermal ulcers and burns, and I would like to receive:

☐ clinical reprints and scientific information on Santyl.
☐ a free in-service training program on the use of Santyl.

Name

Nursing home or hospital affiliation

Office address

City State Zip code

Surviving are his widow, Joan; two sons, Richard and Robert, and five daughters, Debra, Pamela, Diane, Sarah, and Elizabeth, all of Beaver Dam.

Charles B. Nash, MD, 63, Janesville, died Mar. 9, 1973 in Madison.

Born on Feb. 11, 1910 in Paducah, Ky., Doctor Nash graduated from Loyola University School of Medicine in 1936 and served his internship at St. Bernard Hospital, Chicago, and his residency at Cook County Hospital. During World War II he served with the United States Air Force from 1942 to 1946. Prior to coming to Janesville in 1955, Doctor Nash was in private practice and served as health officer in Valparaiso, Ind., and was a clinical associate in eye, ear, nose and throat at Stritch School of Medicine in Chicago.

He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Genevieve; three sons, Joseph, Charles and John of Janesville; and two daughters, Mrs. Clint Cookson and Mrs. Jean Martin, both of Janesville.

Carlos A. Ferrou, MD, 42, Milwaukee, died Mar. 11, 1973 in Milwaukee.

Born on Feb. 6, 1931 in Buenos Aires, Argentina, Doctor Ferrou graduated from the University of Buenos Aires and served his internship at St. Mary's Hospital, Milwaukee, and his residency at the Bronx Hospital, New York, Mt. Sinai and St. Luke's hospitals, Milwaukee. Doctor Ferrou was a physician for the Maternal and Child Health Bureau for the City of Milwaukee Health Department before becoming a staff member of the Northpoint Medical Group, Ltd., in 1972.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Samuel J. Hiller, MD, 67, Milwaukee, died Mar. 13, 1973 in Milwaukee.

Born on Jan. 17, 1906 in Ludington, Mich., Doctor Hiller graduated from Washington University School of Medicine in St. Louis, Mo., in 1932 and served his internship at St. Louis County Hospital.

Surviving are his widow, Helen; and a son, Warren of Whitefish Bay.

Timothy J. Howard, MD, 79, Milwaukee, retired professor of medicine at Marquette University School of Medicine, died Mar. 22, 1973 in Milwaukee.

Born on Jan. 15, 1894 in Milwaukee, Doctor Howard graduated from the Marquette University Medical School and interned at Milwaukee County General Hospital. He served in the Medical Corps of the United States Army during World War I and returned to Milwaukee in 1919 to practice internal medicine. Doctor Howard was a staff member at Columbia and Milwaukee County General hospitals and at Mount Sinai Medical Center. He served as councilor of the 12th district of the State Medical Society of Wisconsin from 1948–1951 and also was a member of the "50 Year Club" of the Society.

He was a member of the Milwaukee Academy of Medicine, Catholic Physicians Guild, American Medical Association and former president of The Medical Society of Milwaukee County and Marquette University Alumni Association.

Surviving are his widow, Ethel; two sons, the Rev. Timothy J., S.J., Tucson, Ariz., and Thomas F., Joliet, Ill.; and a daughter, Mrs. B. James (Mary Helen) Smith, of Whitefish Bay. □

SUPPORT THE CES FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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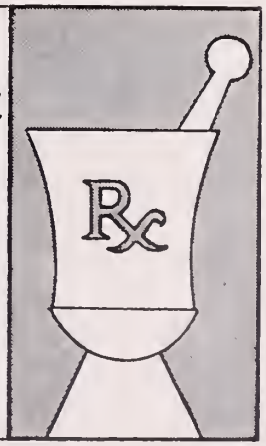

T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of le concern because of this factor)[1]; (2) since SYNTHROID contains on T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Reac the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy

PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3. In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling[2]. T_4 does convert to T_3, though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid®
(sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

FACTS:
Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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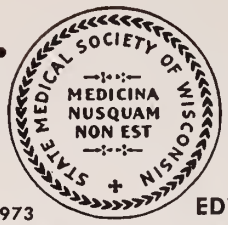
SECTION 

OPHTHALMOLOGY

MAY 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SECTION ON OPHTHALMOLOGY MEETING

The Section on Ophthalmology of the State Medical Society of Wisconsin met in Milwaukee March 27 during the State Medical Society's Annual Meeting. Conducting the meeting was chairman Dr. W. Carson Parks of Milwaukee.

The Section rejected the idea of a bill introduced in the Legislature that would enable morticians to enucleate eyes.

It was reported that the Wisconsin Lions Club Foundation has made a tentative offer to the Wisconsin Society for the Prevention of Blindness of an initial donation of $20,000 and $20,000 annually to be used in setting up a glaucoma detection screening program.

Dr. Herbert R. Giller, Milwaukee, secretary–treasurer of the Section, reported that the Section has $8,000 in dues funds which are available to carry on the legislative and scientific activities of the Section.

Dr. Elmer E. Johnson, Madison, reported that an offer of $1,000, made in 1972, to the Rhode Island Ophthalmology Society to help cover legal expenses in a court fight over the right to dispense eye drops had not been required.

Continuance of the Ophthalmology Page in the *Wisconsin Medical Journal* was approved for another year.

New officers elected for the coming year are: Doctors James C. Allen, Madison, chairman; Herbert R. Giller, Milwaukee, vice-chairman; Lawrence J. Rossman, Wausau, secretary–treasurer.

It was reported that apparently there will be no school of optometry started at the University of Wisconsin–La Crosse.

Prior to the Section meeting on March 27, a group of about 30 ophthalmologists met independently from the State Medical Society meeting to discuss the possibility of starting a prepaid medical insurance program for eye care. One of the administrators of such a plan in Colorado discussed favorable success in selling such a program to large labor unions in Colorado.

Another speaker at this meeting was a director of the Illinois Association of Ophthalmology which was set up because it was felt that the Illinois State Medical Society was not responsive enough to legislative and economic needs of ophthalmologists in Illinois. There was criticism of the State Medical Society of Wisconsin for the same reasons and much talk of setting up a similar organization in Wisconsin.

Establishment of such an organization obviously requires a tremendous amount of time on someone's part. So after all the talking and criticisms of the State Medical Society died down, no one could be found to take on the task of starting a new organization. The discussion of these problems was then renewed in the regular meeting of the Section that afternoon.

The Section responded to these problems by establishing two committees: (1) to study prepaid insurance, and (2) to study the feasibility and cost of hiring the Section's own full-time executive. Many indicated they would serve on committees but no one wanted to be chairman.

Dr. Samuel S. Blankstein of Milwaukee volunteered to be chairman of a committee to study the possibility of starting a prepaid insurance program for eye care in Wisconsin. Others who agreed to serve with Doctor Blankstein are: Doctors Herbert R. Giller, Milwaukee; Paul H. Goldstein, Milwaukee; Donald E. Chisholm, Milwaukee; John E. Ridley, Milwaukee; and Lawrence J. Rossman, Wausau. Doctor Blankstein needs all the help he can and those who would like to volunteer their services can contact him at 2040 West Wisconsin Avenue, Milwaukee, Wisconsin 53233.

Doctors Allen and Giller will be co-chairmen of a committee to study the cost and feasibility of hiring additional staff for the Section at the State Medical Society headquarters. This would, of course, mean an increase in dues for the Section's ophthalmologists.

Dr. Dwain Mings of Monroe was elected the Section's delegate to the State Medical Society. Dr. Lawrence J. Rossman, Wausau, was elected secretary–treasurer.

The scientific program was presented by Dr. Charles E. Iliff of Baltimore and Dr. Guillermo de Venecia of Madison. The meeting was attended by 80 physicians.

DATES TO REMEMBER

Oct. 6–7: Fall Meeting, Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology, Downtowner Motel, Green Bay. President: John Ottum, MD, Green Bay. □

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in two categories: PHYSICIANS EXCHANGE and COMMERCIAL. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. DISPLAY RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701; or phone (area code 608) 257–6781.

PHYSICIANS EXCHANGE

IMMEDIATE OPENING FOR AN ophthalmologist, family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write S. R. Lee, MD, President, or Russel Peterson, Clinic Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 11tfn

WANTED: GENERAL PRACTITIONER to join 3 young general practitioners in college community in southeastern Wisconsin. Two hospitals with 650 beds. Starting salary with progression to full partnership, vacation, sick leave, and profit-sharing benefits. Contact Dept. 374 in care of the Journal. 7tfn

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

WANTED: YOUNG BOARD CERtified or board eligible Obstetrician and Gynecologist to join three-man group which is part of a multi-specialty partnership (40 physicians) in a rural Midwest community serving an area of approximately 250,000. Contact Dept. 394 in care of the Journal. 5–10/73

MULTISPECIALTY CLINIC IN northeastern Wisconsin is expanding; group seeking allergists, general surgeon, and internist. Ultramodern 500-bed hospital located close to the clinic. Excellent recreational area. Salary first year, corporate member thereafter. Small investment second year into corporation. Young group, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 378 in care of the Journal. 9tfn

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTItioner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $30,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

CHIEF OF PSYCHIATRIC SERVices—New full-time position for board certified or eligible psychiatrist. Responsibilities include directing psychiatric inpatient and outpatient services. Inpatient program serving an average of 100 patients with an outpatient caseload of approximately 700 per year. Recently constructed federally approved Mental Health Center. Located at the foot of Lake Winnebago. Many opportunities for indoor and outdoor recreation. One hour drive to Milwaukee or Madison. Challenging opportunity for a dynamic person interested in comprehensive mental health, mental retardation, alcoholism, and drug abuse services utilizing the team approach to develop an expanding program. Salary range $2,654–$2,916 per month. Contact: Randolph W. Kreul, Jr., Director, Fond du Lac County Mental Health Center, 459 East First St., Fond du Lac, Wis. 54935. 5/73

IMMEDIATE OPENING FOR:

1. Internist
2. Family Practice
3. Pediatrician
4. OB/GYN

To join young expanding group. New clinic and excellent hospital facilities adjacent to clinic. Excellent salary and partnership opportunities. New schools, churches and outstanding outside recreational activities. Contact: Lester Hirt, Box 127, Doctors for Medford, Medford, Wis. 54451. 4-6/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

EXCELLENT OPPORTUNITY: General practitioner needed in established practice. Modern clinic adjacent to 85-bed hospital. Progressive community of 6800, excellent schools and recreational facilities. Starting salary $32,000, partnership after first year. Phone, visit or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372–4177. p4-9/73

PHYSICIANS NEEDED: MULTIspecialty group of 24 specialists needs an:

1. Orthopedist
2. Otolaryngologist
3. Family Practitioner
4. Internist

Attractive income arrangements, association membership within 1 year, pension, and extensive fringe benefits. Excellent community of 50,000. Contact R. B. Windsor, MD, 1011 North 8 St., Sheboygan, Wis. 53081. Tel: 414/457-4461. 4-6/73

WANTED: GP FOR A SMALL South Dakota community. New hospital and a clinic closed because our doctor was forced into retirement because of ill health. Excellent income potential for one or two GPs. Located 50 miles west of Aberdeen. Excellent hunting and fishing. Contact: Len Meysembourg, Adm., Bowdle Hospital, Bowdle, South Dakota. Tel: 605/285–3501. 5/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

EMERGENCY DEPARTMENT physician to join three (3) other physicians presently serving a 350-bed community hospital, located in a midwest city of 60,000 with outstanding living, recreational, and cultural facilities. Forty-hour week with competitive salary and benefits. Full specialty backup. Contact: D. E. Kershaw, St. Francis Hospital, 709 S. 10th St., La Crosse, Wis. 54601. Tel: 608/782–8022. 5–7/73

IMMEDIATE OPENINGS FOR physicians in OB–GYN specialty to establish a successful practice in a multi-specialty clinic located close to hospitals. In-clinic medical student teaching opportunity. University and college city. Year around indoor and outdoor family activities of all types. Salary plus excellent benefits first year and corporate member thereafter. Interview expenses paid. Call collect to D. W. Shea, MD, Beaumont Clinic, Ltd., 1821 S. Webster Ave., Green Bay, Wis. 54301. p5–9/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468–2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3–8/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

DIRECTOR
OF
MEDICAL
EDUCATION

Large, voluntary, general hospital located in Chicago, offers an excellent opportunity for a full time Director of Medical Education. Prefer a physician experienced in coordinating residency programs, University/Community hospital relationships and inhospital postgraduate education programs. Competitive salary and excellent benefits. Consulting privileges considered. Submit resumé to:

Chairman, DME Search Committee

HOLY CROSS HOSPITAL
2701 W. 68th Street
Chicago, Illinois 60629

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

IMMEDIATE OPENING FOR Internist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545; tel: 1–608/752–7811. 4tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

GENERAL PRACTITIONER WITH strong interest or background in industrial medicine needed by eleven-man multispecialty clinic. Full time or part time. Salary negotiable, many fringe benefits. Asssociate status possible after one full calendar year. Contact: Administrator, Medical–Surgical Clinic, S. C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215. 2–5/73

GENERAL PRACTITIONER wanted to share the good life in beautiful KEWAUNEE, Wis. We can offer you, an accredited hospital, office and clinic space, crime free community, good schools, three fine churches, beautiful homes, beautiful people, Lake Michigan with its fabulous trout fishing, water skiing, boating, snowmobiling, skiing, golfing and the PACKERS. Packer Country is just 25 miles west and lastly—MONEY. Per capita income is high. We see our doctor and we pay our bills. Write to: Doctor Search Committee, P. O. Box 222, Kewaunee, Wis. 54216. 3tfn/73

WANTED—GENERAL OR FAMILY practitioner to join 3-man group. 45-bed hospital in community. 35 miles from St. Paul. Baldwin Clinic, S.C., Baldwin, Wis. 54002. Tel: 715/684–3326. 10–5

WANTED: FAMILY PRACTITIONers and internists to join 20-man mixed specialty clinic. Teaching opportunities guaranteed. Salary with corporate ownership in two years. William Rock, MD, East Madison Clinic, 1912 Atwood Ave., Madison, Wis. 53704. 6–5

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living; discover Watertown, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy going pace of a residential city.

We urgently need family practitioners, internists and other specialties; exceptional opportunities for private or group practice growth.

Our new community health care center with its beautiful 110-bed general hospital, connecting (but separate) 24 unit medical–dental office building and connecting 120-bed nursing home, was completed in 1971.

Watertown is a progressive community, ideally located equi-distant between Milwaukee and Madison in southeastern Wisconsin's lake district; the community has a trade and medical practice area serving 40,000 people; many new schools, parks, trees, social and recreational facilities; a stable economy.

Enjoy the best of two worlds: practice in a tree-shaded medium size city with access to the medical centers at the University of Wisconsin and the Medical College of Wisconsin (formerly Marquette University School of Medicine). The medical staff is leading and supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261–4210. 3tfn/73

WELL TRAINED PATHOLOGIST, AP (CP eligible), excellent references, special training in oncologic pathology, military service completed, seeks position as associate pathologist or as director. Contact Dept. 393 in care of the Journal. 4tfn/73

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial–agricultural community with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693–3021. This ad endorsed by present doctor. 2–7/73

CAN A YOUNG FAMILY PRACTItioner find: medical, social and economic happiness in "THE NORTH WOODS"? Soap Opera? Not quite! It's all here in Eau Claire, Wis. We're all GPs and we'll be moving in a new office. Don't blame us if you get here too late! Write: G. G. Giffen, MD, Putnam Heights Clinic, P.O. Box 970, Eau Claire, Wis. 54701. 2–6/73

WANTED: DOCTOR (SEMI-retired) interested in part time work assisting group in gynecological work in Milwaukee area hospital. Must be licensed in State of Wisconsin. Contact Dept. 389 in care of the Journal. 3–5/73

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

PRACTICES AVAILABLE

LARGE PRACTICE AVAILABLE: Before you make any decision please see this practice. Good for two GPs. Do surgery, GP, OB-GYN. Well built and furnished practice. All recreation available right here with hospital in town. Contact Dept. 392 in care of the Journal. p4-5/73

MEDICAL FACILITIES

FOR SALE: DISABLED SURGEON and physician offers following equipment set-up for two examining rooms. Two metal examining tables, utility tables to match, stools, jars, containers, etc. Floor light, adult and baby scales, and misc. trays, splint equipment as is. Also lab equipment including: CS & E Incubator, Adams Jr. centrifuge, Leitz photrometer, blood sedimentation apparatus, and miscellaneous lab glass equipment. Birtcher Hyfercator, small American Autoclave and protractors, plus other syringes and sundries included. Bulk price $1500. All equipment in good condition and stored at present. Located 30 miles east St. Paul. Contact: Mrs. R. R. Davis, New Richmond, Wis. 54017. Tel: 715/246–2189 or 2289. 5/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g4tfn/73

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

FOR SALE: MEDICAL BUILDING. 2100 square feet. Two divided suites. Separate, central gas heat and air conditioning. Paved parking lot. Excellent location. Residential area. Five minutes from either hospital. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634–6833. 3tfn/73

WILL BUILD TO YOUR NEEDS. Village of Pewaukee located north end of Pewaukee lake, 18 miles west of Milwaukee. 3500 sq. ft. of buildable space plus off street parking. Adjoins established dental office of 8 years. Call or write: R. E. Schneider, DDS, 234 Oakton Ave., Pewaukee, Wis. Tel: 414/691–2630. p5/73

COMMERCIAL

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

WANTED: USED MICROSCOPES. Nicaragua/Wisconsin Partners of the Alliance have requests for used microscopes suitable for use in Nicaraguan high schools for teaching purposes. Donations to the Partners are tax deductible. Please notify Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701, if you have a usable microscope. g5tfn

PUBLICATIONS

Adaptations and Techniques for the Disabled Homemaker. Presents a general approach to saving energy and simplifying housework as well as directions for accomplishing specific tasks. Adaptive devices chosen for inclusion in the manual are simple and inexpensive. 32-page manual is designed as an aid for occupational therapists, nurses, patients and families. Available from the Publications Department of the Sister Kenny Institute, 1800 Chicago Ave., Minneapolis, Minn. 55404. Price: $1.75 per copy. Prepayment is requested on orders under $5.00. 5/73

What Do We Know About Allergies. Subject is explored in the new Public Affairs Pamphlet, by Michael H. K. Irwin, MD, MPH. Available (No. 486) for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, NY 10016. 5/73

Mental Health: Principles and Training Techniques in Nursing Home Care. New publication issued by the National Institute of Mental Health of HEW's Health Services and Mental Health Administration. Based on proceedings of a national conference sponsored by the Gerontological Society, in cooperation with the Continuing Education Branch of the NIMH Division of Manpower and Training Programs. Conference was designed to develop workable models of mental health training for those who provide care for the approximately one million elderly persons residing in nursing homes. Training programs described in publication stress the application of mental health principles to provide for the understanding and incorporation of positive mental health attitudes within a nursing home. Copies available (DHEW Publication No. HSM 73–9046) from: Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at $1.25 each. 5/73

Depression: Causes and Treatment. A primer on mental health problems written by Theodore Irwin. New Public Affairs Pamphlet, No. 488, available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, NY 10016. 5/73

Guide for School Health Examinations. 40-page, 1970 revised edition, prepared and published by the State Medical Society's Division on School Health in cooperation with the Wisconsin State School Health Council, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, at cost of $1.00 per copy to be sent with order.

GUIDELINES FOR BLOOD–ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

ANNOUNCEMENTS

A NEW FACT SHEET, "Improvements in your social security cash benefits" is available free upon request at any social security office. 5/73

INTERESTED SMS MEMBERS may obtain from the AMA a copy of a new, 185-page AMA paperback which consists of brief information on approximately 200 medical topics, plus references to AMA activities, policies and publications in each field. Send $1 per copy to AMA, 535 N. Dearborn St., Chicago, Ill. 60610. The reference book is available at 50¢ to medical students, interns, and residents. 4/73

ALL PSYCHIATRISTS WHO HAVE not already taken the Psychiatric Knowledge and Skills Self-Assessment Program (PKSAP), are urged to apply for it by writing to the APA, 1700 18th Street, N.W., Washington, D.C. 20009. The test stresses patient management problems, allows participants to score themselves in relation to peers, and earns credits for continuing medical education. 4/73

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20–21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

CURRENT PERINATAL INFORMATION IN DIAL ACCESS LIBRARY. The Wisconsin Dial Access Tape Library is a source of immediate practical information for doctors and nurses providing perinatal care. Over 40 tapes are now available dealing with such problems as abruptio placenta, bacteremic shock, respiratory distress syndrome, hypoglycemia of the newborn, etc. Tapes are continually revised by the authors. This service is available to physicians for a $25 subscription fee. Nurses can utilize this service free of charge. For further information and a complete list of dial access tapes write: Dial Access Library, 610 North Walnut Street, Madison, Wis. 53706.

ORDERS for Emeritus Dean William S. Middleton's new book, "Tangible and Intangible Values in Modern Medicine," are now being accepted by the Wisconsin Medical Alumni Association office. The 300-page book contains a collection of Doctor Middleton's 35 best nonclinical writings — articles and speeches that he has presented to medical and lay audiences over the past several decades. Cost: $11.50. Contact Mrs. Froland in the Medical Alumni office, 610 N. Walnut, Madison. Tel. 608/263–4914.

Wisconsin Diabetes Association

will again sponsor a camp experience for diabetic children at

CAMP SIDNEY COHEN

located on Lake Nemahbin in Waukesha County, 30 miles west of Milwaukee

Sessions are:

Ages 8–11: July 20–27

Ages 11–14: July 28–August 11

Parents of diabetic children who might benefit from the experience can write WDA, 225 East Michigan St., Milwaukee, Wis. 53202, and request an application. Deadline for applications is May 31. WDA is recruiting camp personnel (2 nurses, a dietitian, and 2 teenage diabetics to serve as camp aides. The camp aides must be at least 17 and able to set a good example for the campers to follow). Interested individuals can contact WDA to apply for these positions.

WISCONSIN PROFESSIONAL SOCIETY ON ADDICTIONS. Membership in the Wisconsin Professional Society on Addictions is open to those who are in a position of directing, administering or coordinating councils, information and referral centers, clinical settings for alcoholism or drug abuse or their divisions who have submitted a written application for membership. Membership fee is $10 annually. Applications should be sent to: William Roberts, 4200 Marquette Drive, Racine, membership chairman. John W. Sell is president of the society whose primary purpose is "to foster coordination, insure cohesiveness and upgrade effectiveness within the information–referral centers throughout the state."

FILMS

The Edge. The MEDIHC (Military Experience Directed Into Health Careers) Program has announced a new, 20 minute, 16mm color film entitled "The Edge." Filmed at hospitals and health facilities in Missouri, actual employers present their views on utilizing medically trained and experienced veterans in their facilities. It's available on loan, or Mr. Piernot, MEDIHC Coordinator, will present the film to you or to a gathering of your associates. Send inquiries to MEDIHC, Wisconsin Health Council, Inc., Box 1109, Madison, Wis. 53701.

Balance Sheet. The Illinois Governor's Committee on Employment of the Handicapped has recently released this 22-minute color film on the handicapped person as a contributing member of the community. New state and federal law emphasizes equal opportunities for all citizens. One of the least-mentioned of the minorities are the physically and mentally handicapped person. "Balance Sheet" reflects attitudes of the employee/businessman as well as the handicapped person and social service agency. Over two hundred hours of in-depth interviews with handicapped people developed an intensely human film that keeps business realities in perspective. "Balance Sheet" attempts to dispel the myths and misconceptions about the handicapped person. Many types of work are depicted; from a double amputee farmer to a blind engineer in a radio station. For more information on availability contact the Illinois Governor's Committee on Employment of the Handicapped, 188 W. Randolph, Chicago, Ill. 60601.

Bicornuate Uterus, Diagnosis and Management. New educational film now available for showing to medical groups from E. R. Squibb & Sons, Inc. In the 27-minute sound film, Dr. Y. Douglas Taguchi, F.A.C.O.G. discusses bicornuate uterus, the commonest uterine anomaly; three techniques of metroplasty, a corrective surgical procedure; and presents a demonstration of one of the techniques. Various types of bicornuate uteri are illustrated with detailed drawings. Dr. Taguchi presents an actual demonstration of the Tompkins technique of metroplasty. The Cesarean section that follows shows no evidence of weakness anywhere along the previous metroplasty suture line.

Dr. Taguchi is a Diplomate of the American Board of Obstetrics and Gynecology, Department of Obstetrics. He is on the staff of the Southern California Permanente Medical Group and the Kaiser Foundation Hospitals, Los Angeles.

The 16mm color film, produced by Billy Burke Productions of Hollywood, may be obtained for professional groups by writing to E. R. Squibb & Sons, P. O. Box 4000, Princeton, N. J. 08540.

Thyroid Disease as a Late Sequela of Radioactive Fallout is the title of a new film from the Flint Laboratories division of Baxter Laboratories, Inc. The 30-minute, full color–sound film was produced by Flint in conjunction with Brookhaven National Laboratory and the Atomic Energy Commission. It specifically covers the subject of thyroid disorders as related to accidental fallout of radioactive iodine on the people of Rongelap Island in 1954. The film has won the Gold Camera, Cine, and New York Film Festival awards. Booking arrangements may be made through: Professional Services Department, Flint Laboratories, 200 Wilmot Road, Deerfield, Ill. 60015.

COMPUTERIZED LITERATURE SEARCHES

IN

Index Medicus

NOW AVAILABLE FROM

MIDDLETON MEDICAL LIBRARY

Middleton Medical Library, University of Wisconsin, Madison, is now offering MEDLINE service free of charge to any resident of Wisconsin. MEDLINE is a computerized on-line bibliographic searching capability of the medical literature in *Index Medicus*, developed by the National Library of Medicine. Eventually, there will be a network of about 150 institutional users with individual terminals linked to the data base in Bethesda, Maryland, by long-distance telephone lines. Presently, Middleton Medical Library is the only library in the state offering this service.

Citations stored in the data base cover the period January 1969 to the present and may be retrieved by subject, author, journal, language, and date of publication.

For further information contact

Medical Library Service
Room 202
Middleton Medical Library
1305 Linden Drive
Madison, Wisconsin 53706

Or call collect (608) 262–6524

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

June: Spring meeting, Wisconsin Neurology Society

June 13–14: Annual Meeting, Wisconsin Regional Medical Program, Pioneer Inn, Oshkosh.

June 14–16: Reproductive Endocrinology Conference, UW Center for Health Sciences and UW Extension, Wisconsin Center, Madison.

July 14–15: Council Meeting, State Medical Society of Wisconsin, Madison.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

July 29–Aug. 3: Symposium on Alcoholism and Other Drug Abuse, Mt. Senario College, Ladysmith (endorsed by the Education Committee of the Wisconsin Academy of Family Physicians for 33 hours of postgraduate credit).

Sept. 8–9: Wisconsin Allergy Society meeting.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Sept. 14–15: Wisconsin Surgical Society Fall Meeting, Gateway Resort, Land O'Lakes.

Sept. 21–23: Wisconsin Radiological Society meeting, Sheraton Motor Inn, Madison.

Sept. 22: Second annual North Central Clinical Cancer Conference, Marshfield. Sponsored by the American Cancer Society and the Marshfield Clinic Foundation for Medical Education and Research.

Oct. 6: Wisconsin Society of Pathologists meeting, Bellin Memorial Hospital, Green Bay.

Oct. 6: Fall Physicians Conference (Cancer Scrimmage), Madison. Sponsored by the American Cancer Society, UW Department of Continuing Medical Education, and the Division of Clinical Oncology.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

1973 NEIGHBORING STATES

Jun 1: Emergency Cardiac Care Symposium, Iowa Heart Association, Johnny & Kay's Hyatt House, Des Moines. Info: Iowa Heart Association, 529—36th St., Des Moines, Ia.

June 10–15: 1973—Midwest Institute on Alcoholism, Western Michigan University, Kalamazoo, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

Oct. 20–26: Annual Otolaryngologic Assembly of 1973, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

1973 OTHERS

June 11–16: General Practice Review, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

June 13–14: Cleveland Symposium on Infectious Diseases, Cleveland Clinic Educational Foundation and the American Society for Clinical Pharmacology and Therapeutics, Ohio.

June 14: Eighth Annual Continuation Course on "Clinical Electroencephalography," Statler–Hilton Hotel, Boston, Mass. Info: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55901.

June 15–16: Annual Meeting, American Electroencephalographic Society, Statler–Hilton Hotel, Boston, Mass. Info: Mrs. Margaret H. Henry, Exec. Secy., American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

June 21–23: Postgraduate Course on Newborn Problems, Disney World, Lake Buena Vista, Fla. Sponsored by the American Academy of Pediatrics and presented by the U of Florida, College of Medicine.

July 16–20: Internal Medicine, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

July 26–28: Postgraduate Course on Biliary Tract Disease, American Gastroenterological Association, Playhouse, Aspen, Colo.

July 29–Aug. 1: Pediatrics, U of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Aug 2–4: Fifth Aspen Conference for Dermatologists, Rocky Mountain Dermatological Society and University of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Sept. 19–22: District V, American College of Ob–Gyn, Pantland Hotel, Grand Rapids, Mich.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov 29–Dec 1: National Conference on Virology and Immunology in Human Cancer, Waldorf–Astoria Hotel, New York, N. Y. Sponsored by American Cancer Society and National Cancer Institute.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

June 24–28: Annual Convention, New York.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

MEDICAL MEETINGS . . .

1974 WISCONSIN

Jan. 26–27: Council Meeting, State Medical Society of Wisconsin, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

1974 NEIGHBORING

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

Oct. 21–25: Clinical Congress, American College of Surgeons, Miami Beach, Fla.

* * *

Annual Clinical Congress, October 15–19, Chicago. Official headquarters will be the Conrad Hilton Hotel, with sessions at McCormick Place and several area hotels.

The program will include:

- 16 *postgraduate courses* (accredited by the Council on Medical Education of the American Medical Association).
- More than 250 research-in-progress reports, called the *Forum on Fundamental Surgical Problems.*
- Some 89 *panel discussions and symposia* in general surgery and the surgical specialties.
- *Correlative Clinic,* case studies showing the value of close cooperation between general surgery and the surgical disciplines.
- *Operative telecasts* from Loyola University Hospital, Maywood, Ill.
- More than 90 *films and Cine Clinics* including those in "spectacular" surgery.
- *Special sessions* in cancer, trauma, surgical education, operating room environment and international relations.
- *"What's New In Surgery"* resume.
- Approximately 400 *scientific and industrial exhibits.*

INFORMATION ON FEES: Fellows of the College whose dues are paid to Dec. 1972 may register free. Initiates, members of the Candidate Group and surgical residents register free. Non-Fellows pay $90, non-Fellow doctors in the Federal Services pay $50. *Everyone* taking one of the 16 postgraduate courses must pay the fee for the course selected.

A pre-Clinical Congress *Scientific Communication Workshop* will be held Oct. 13 and 14. (*Separate* $100 fee, which includes two luncheons. Special registration form available from Publications Department.)

The Clinical Congress of the American College of Surgeons is open to all doctors of medicine. Official forms for registration, housing and postgraduate courses available after June 1. Contact: Fred Spillman, Convention Manager, American College of Surgeons, 55 E. Erie Street, Chicago, Ill. 60611, phone (312) 664–4050.

Course in Laryngology and Bronchoesophagology. The Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, will conduct a continuing education course in Laryngology and Bronchoesophagology November 12 to 17, 1973. Course is limited to 20 physicians.

It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians write directly to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, Ill. 60612.

Annual Otolaryngologic Assembly of 1973 will be held October 20 through 26, 1973, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology of the Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists. Designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to the mailing address: OTOLARYNGOLOGY, P. O. Box 6998, Chicago, Ill. 60680.

A separate, but correlated course, **"Conference on Radiology in Otolaryngology and Ophthalmology"** will be held on Friday and Saturday, November 23 and 24. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, Abraham Lincoln School of Medicine, P. O. Box 6998, Chicago, Ill. 60680. □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOK REVIEWS

Approach to the Medical Care of the Sick Newborn.

By Sophie H. Pierog, MD and Angelo Ferrara, MD. The C. V. Mosby Co., St. Louis, Mo. 1971. 292 pages. Price: $11.50.

In general this is a good book for 3rd/4th year medical students, nurses in neonatal intensive care units, and certain physicians involved in the care and teaching of care of sick neonates.

I personally do not like the box-type arrangement of the chapters in Section III—but many people like material outlined in that form. In other chapters, the diagrams are well done and stress important points.

The references in most areas are as current as can be expected from a book, and usually appropriate. The matter of referring to a group of references by an asterisk is new to me, but probably saves text space.

There were only a few places where one could positively disagree with the content and accuracy of the material presented. However, there are places where the book is quite incomplete and/or in error. I differ with the use of glucogen in infants of diabetic mothers (chapt. 18, pg. 145); the section on bilirubinemia (chapt. 19, pg. 149) is incomplete, for example, mention of intermediates in bilirubin metabolism are omitted (probably intentionally); and in one place in an earlier chapter an enzyme name is in error (pg. 54, line 22). Frequently, however, the possibility of different therapy and altering therapy due to other criteria are left open and this lack of dogma in the approach to all diseases of the newborn is a good point about the book.

The book is comprehensive in coverage—including areas in prenatal considerations, parents, procedures, equipment and nursery design, and a chapter on the effect of drug addiction on the fetus and newborn. Section VI, regarding family and community, stressed the role of the physician too much, since many of these responsibilities can be handled by social workers and other paramedical persons.—RICHARD D. ZACHMAN, MD, PhD

Current Concepts in Dyslexia.

Edited by Jack Hartstein, BS, MD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 212 pages. Price $12.00.

Doctor Hartstein has edited a book entitled, "Current Concepts in Dyslexia," which might better be entitled, "Current Concepts in Learning Disorders, Including Reading Disabilities." It is unfortunate that the author still stresses the term "dyslexia," since in recent years workers in the field of reading disabilities have attempted to understand this under the broader concept of learning disorders. The editor is certainly cognizant of the fact that the interdisciplinary approach to these problems is necessary, since he has enlisted the opinions of educators, speech pathologists, audiologists, orthoptic technicians, psychologists, as well as doctors of medicine in the fields of pediatrics, neurology, psychiatry, and ophthalmology.

Those who wish to learn more about the workup involved in analyzing the problem cases will readily find this information, including many case reports used as examples to illustrate specific points. In the majority of cases after the appropriate analysis of the child has been made, the remedial therapy must be instituted by the educator in the school. The teacher must understand the child's strengths and weaknesses in order to create programs that permit him to progress through emphasis of his strengths, rather than sometimes waste

time and effort in attempting to dwell on his weaknesses.

Throughout the text emphasis is continually placed on better communications between the people involved outside of the school, in the family, and within the school. Within the school it is stressed that the regular classroom teacher be well informed on what the special education teacher, or reading specialist is attempting to accomplish in the treatment of the particular child. It is also emphasized that there may be important environmental factors in the home that contribute to the learning disability, and the parents can often be of great help. This book should be of great interest, and supply much information to physicians, as well as educators, and nonmedical specialists who wish to increase their knowledge in the area of learning disabilities.—HERBERT GILLER, MD

The Mental Health of the Child

Program Reports of the National Institute of Mental Health. Superintendent of Documents, US Government Printing Office, Washington, D. C. 20402. June 1971. 588 pages. Price: $5.00.

This book is an excellent compilation of recent research on children supported by the National Institute of Mental Health. There are a total of 43 research reports presented in four groups. These are: (1) Studies and Demonstration in Prevention, (2) Factors that Influence the Child's Mental Health, (3) Advance in Diagnoses and Treatment, and (4) Basic Studies of Child Development.

The editor is to be congratulated in making this diverse group of reports meaningfully related and easily read. It is pointed out in the foreword the greatly expanded demand for children's psychiatric services that has occurred over the past fifteen years. Currently over 600,000 children are being treated in inpatient and outpatient psychiatric facilities in the United States. This along with the rise in juvenile court appearances of children and the increase of adolescent suicides by 60% in the past 20 years makes these research reports particularly appropriate and timely for all those interested in children's personality growth and development.

It is impractical to try to acquaint the potential reader with details of the content of these reports because of their diversity and number. Topics ranged from *Delinquent Girl Gangs* to *Parental Behavior and the Origins of Schizophrenia.* Other topics ranged from *The Impact of Visual Media on Personality* to *The Physiological Imprint of Learning.* In every article the material was presented in a concise but interesting fashion without an over-abundance of either technical jargon or difficult to understand mathematical tables.

This book could be read profitably by general practitioners, pediatricians, child psychiatrists, nurses caring for children, psychologists, social workers, and teachers.—HAROLD F. BORENZ, MD

Baby's Recipe Book.

By Linda McDonald. A. S. Barnes and Co., Inc., Box 421, Cranbury, N.J. 08512. 1972. 271 pages. Price: $8.95

The author notes that "there are cookbooks for everything and everyone except 'baby'," so she proceeds to fill the void. The delightful picture of a child on the dustcover is the best part of this book.

The author's purpose appears to be to show mothers "a more healthful way, or even a less expensive way" to feed a baby. With her apparent lack of understanding of principles of nutrition and sanitation, neither goal is achieved.

Home preparation of baby foods, with no precautions as to the bacterial hazards involved, is recommended: commercial baby foods pose health problems; the "store-bought variety" may cause food poisoning. Rather than buying commercially packed products, the author advises using a baby food grinder to prepare and freeze foods in the home for later use. She warns that any thawed vegetables or fruit should be used "within two or three days, and meat within four." The baby should never be fed "from the storage container"; if the food is not finished during one feeding, "baby saliva will find its way into the unused food, and . . . digest the food as it sits in the refrigerator." She explains that if a freezer is not available, a week's supply can still be ground at one time—"just store the food in a tightly covered jar in the coldest part of the refrigerator."

In spite of many unrelated snatches of quotations from scientific reports (those left over are included in an "article list" at the end of the book and are very freely interpreted), there appears to be a profound lack of knowledge of nutrition and of groups setting standards. No mention is made of quantities of food (other than a serving) or the timing of the introduction of iron and vitamin C containing foods. In fact the statement is made, "Breast milk, not extra food or supplements is the perfect food for your baby for the first four to six months."

This book is replete with misinformation and lack of information. There is little to recommend it.—RUTH DICKIE, PHD

The Care of Minor Hand Injuries.

By Adrian E. Flatt. The C. V. Mosby Co., St. Louis, Mo. 1972. 293 pages. Price $21.50.

The information presented in this book if utilized properly will allow for the safe and adequate treatment of the great majority of hand injuries seen in an Emergency Room. The author's broad training, experience, expertise, and diligence of documentation are obvious in this excellent text.

The book is divided into two sections. The first deals with principles of anatomy, examination, and treatment. The second contains detailed instruction for the care of specific injuries. Admitted repetition exists as fundamental principles are reemphasized in section II. Attention to detail and completeness are clearly evident throughout the book. Discussion often includes duration of impairment and expected disability.

Emphasis is on injuries that can be treated on the outpatient basis, but recognition of injuries best treated in the operating room are also discussed. The scope of the book is certainly greater than the title might implicate. Only proven methods of treatment are presented.

The book is written in a delightful personalized style which makes it more enjoyable reading than most American texts. The adequate and excellent illustrations correlate well with the printed text. Numerous references are present. The good index and orderly arrangement of text make the book ideal for Emergency Room use.

The book has much to offer physicians treating hand injuries. Its content is ample for thoughtful study and its arrangement is ideal for quick reference.—ANDREW A. MCBEATH, MD

Pediatric Therapy

Fourth edition. Edited by Harry C. Shirkey. The C. V. Mosby Co., St. Louis, Mo. 63103. 1972. 1221 pages. Price: $34.50.

Excellent outline of pediatric therapy. The quality of the authors is excellent. The material has been put together by Dr. Shirkey in a most satisfactory and comprehensive way. The book is up-to-date in most areas. The individual chapters are clear and well outlined. This is a book on pediatric therapy that I would recommend for students and staff.—JOHN A. MANGOS, MD

Instructional Course Lectures. Vol. XX.

By the American Academy of Orthopaedic Surgeons. The C. V. Mosby Co., St. Louis, Mo. 1971. 244 pages. Price: $20.00.

During World War II selected lectures given at the Annual Meeting of The American Academy of Orthopaedic Surgeons were published annually in book form and entitled Instructional Course Lectures. For a time in the late 1960s these lectures were selected even more stringently and appeared in the American editions of the *Journal of Bone and Joint Surgery.* More recently, with the continued expansion of the Instructional Course Lecture series given at the annual meeting of the American Academy of Orthopaedic Surgeons, the selected subjects from these lectures have again begun to appear in separate volume form. The currently available number, Vol. XX, is a compilation of selected lectures given at the Academy meetings of 1970. Several timely and practical clinical subjects have been presented and are grouped in a very logical fashion.

This book, and others of the series, presents basic clinical material representing current status of various orthopedic subjects. In the current issue an excellent survey of cerebral palsy is given, including the general principles of diagnosis and treatment emphasizing the team approach as well as specific deformities of the foot, knee and hip and their treatment. In a similar way, principles of lower extremity bracing is covered in a most comprehensive way in papers by four authors grouped into one chapter. A very, very practical paper relating to the painful shoulder is offered and the principles espoused would be of value to anyone treating the very

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March 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1973:

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BOOKSHELF . . .

commonly encountered painful shoulder. Another timely topic, that of advanced degenerative arthritis of the hip is covered from several aspects, including cup arthroplasty, total hip replacement, osteotomy, and muscle release operations.

Additional chapters include an excellent one on orthopedic infections with emphasis on pathophysiology and treatment and a similar chapter on hemophilia. The chapters on surgical anatomy and exposure of the knee joint, osteoarthritis of the knee, synovial fluid and synovial membrane abnormalities in arthritis of the knee joint, are also very valuable chapters, as is the very comprehensive discussion of fractures of the shafts and distal ends of the forearm bones.

The Instructional Course Lectures in Vol. XX continue to form a current standard of reference and is a necessary part of all hospital libraries and is felt to be mandatory reading for virtually all orthopedic surgeons.—GEORGE L. LUCAS, MD □

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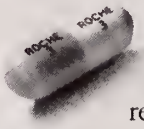

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-800-F (10/71)
For complete details, including dosage, please see full prescribing information.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by form AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated ir crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients...

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econon impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inter ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmacis made in the absence of clinical kno edge of the patient, could expose hi to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

Advertisement

hould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Placidyl®
(ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

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Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

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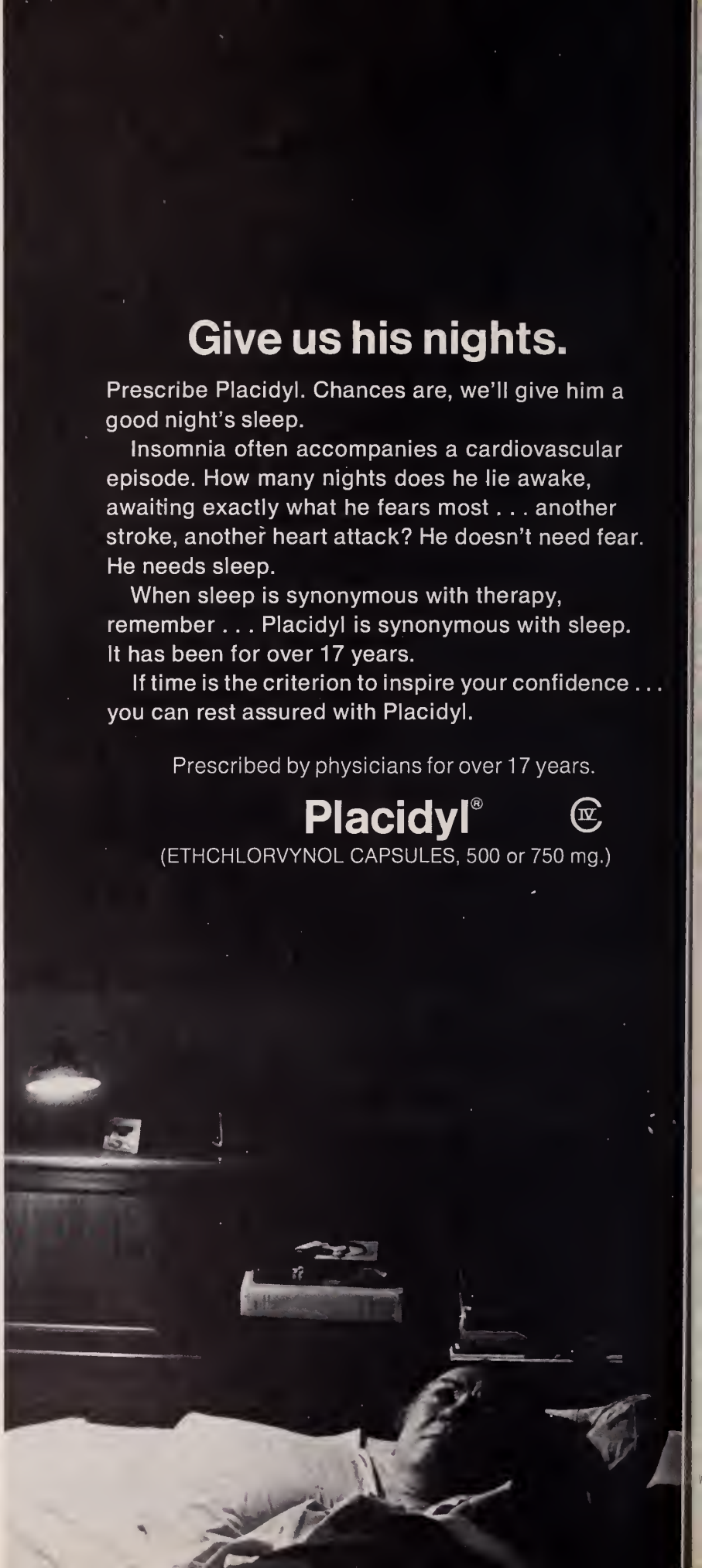

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Vive la Difference

LAST MONTH THE MOST difficult problem of peer review was seen to be the struggle about whether, when, and how to speak of errors. As with sore teeth at the dentist, each pain in turn seems the worst. Next month, the problems of misperceptions will surely be the worst. But in this essay, the second issue, the differences of practical or theoretical approaches to medical problems may at once be our strength and our weakness, but certainly seems great right now.

In some fairy land of the future, medicine may be practiced without reference to doubts or to different systems of approach. Today we do not have such an ideal state. Surgeons feel deeply about whether two or four coronary bypasses should be done at one time. It does little good to call one form of medical treatment "conservative" and another "radical," for what really takes place is a fundamentally different system of thinking about a given struggling person in pain. Especially in psychiatric treatment there is no point of meeting at all between those who routinely suppress symptoms, with drugs or shock, and those who would support some sort of effort toward self-growth, with group or some sort of individual therapy.

Now some of us would like to believe that we have scientific proof that our way or our systems are right or best. Most of the steam engendered among doctors does not come from the relatively cold dialectic, however. It comes from fierce holding onto what we *believe* to be right. As often as not, the opponent is accused not only of being wrong but also of being intellectually dishonest for not seeing the problem our way. Anyone who has socialized with physicians, even the extent of professional meetings, or for any length of time in a hospital's physician lounge has seen it happen. The lament runs like this: elaborate details of some case all organized toward some diagnostic or therapeutic conclusion; intense concern over disagreement from a peer in last diagnostic conference, based on malice, on stupidity, on sloth or dishonesty; later a most similar reaction from the peer but with details of the case now rearranged so that even a lay person could easily see the only conclusion possible is the one *he* came to!

I'm tempted now to use the privilege of this page to tell you about several cases where my diagnosis and treatment plans were so clear, but where serious disagreement existed in the mind of the family, the family physician, some uncle in Chicago who is an "outstanding surgeon," and their neurologist. All thought my view was fraud.

Now what do you do with all this in peer review? Do we submit to whomever can become dominant in some political sense? Do we take a vote, statewide or nationwide, thinking numbers will prove something? Well, of course, the reader could say, why not let the scientific validity stand for itself? This one is even more difficult, as I well remember both in graduate school, even in medical school and certainly during my year at the Clinical Center of the National Institutes of Health. All the persons quoted in the little examples above have had scientific training, of many sorts. I've had a bit of it myself, but does one apply mechanical (scientific) certitude to a human patient; or does one seek scientific skill in how to approach a person in pain; and how does one know how much of his pain is due to extraneous factors (germs, trauma, and the like) and how much of his pain is due to the way he lives (his habits, his perceptions, and the like)?

I find it often takes me hundreds of hours spent with one person to really come near grasping his existential pain, or to gather together a few of the reasons why he abuses his body with tobacco, or alcohol, or tranquilizers, or even the more notorious (but often less dangerous) soft drugs such as codeine, cocaine, and others.

If we strike a bargain with one another, where does that leave us; i.e., you practice your way and I'll practice mine and we will call each other—in public at least—ethical. To do this would be convenience and bring scorn if not wrath down upon our heads, from the public and from the public defenders, be they self-styled publicists or self anointed judges with semi-official sanction of the body politic.

What is left to us? I believe we can stand firm only if we consistently and firmly resist all attempts to force us, or any small group of us (even psychiatrists) into an oversimplified statement of our position, and especially regarding a given disease entity, for example, depression. The pressure is on, from the public itself this time, not from a nefarious little band of political conspirators as we used to be so fondly against! This makes it easier, in the sense that we must only come across to the people we see every day, our patients, and do not have to fight sophistries. But it is harder, too, for it needs day-by-day attention to three main points: (1) resist pressure for easy, dogmatic, and complete answers to most medical questions, (2) convince the patient or the public spokesman that in spite of no sure answer we do know something about the subject, and that he should listen while we (3) explain what we know of the complexities of human organization, both body and mind, and help him learn to use this knowledge to his advantage.

Now those who have read this far have already demonstrated that they have the capacity for deferring immediate answers, for remaining with me for my partial knowledge or impression, and perhaps have gained a bit of perspective on this most vexsome issue of peer review. By this fact the reader can pass on to his patients the same threefold approach. Many physicians do this, and most believe they do. But it is so easy to be stampeded into a short determinant answer. The pressure for this comes partly from ourselves, as I found when I needed to pare words for *Ask the Doctor* newspaper column. It also comes from each of our needs to know something for sure. But equally our patients demand short, sure answers, as some of my readers demand short, snappy editorials. They insist, and reward us with charismatic crowns if we comply—but only while we comply. Such dyads are doomed to fail for they are merely facets of the same extreme need—for quick answers.

If we can hold off our own surety—EVEN IN THE FACE OF PEER REVIEW—then and only then can medicine survive and grow. If we do not "celebrate the differences between ourselves," we will become subject to stultifying codifications of our practice, according to one system or another that appears to work and that will be that. Vive la difference!—RH

GUEST EDITORIAL

The Physician in Public Relations

THE MODERN STANCE of public relations is somewhere between the Judeo-Christian concept of covertly performing good deeds and the modern day pragmatic approach of Mark Twain who said that "ain't no good doing nothing unless someone else knows about it." Entrepreneurs and businessmen of every walk of life exercise the prerogative of public relations; the physician and his fellow professionals have either erroneously dismissed it as

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inconsequential or haughtily dismissed it as unnecessary.

Public relations is and must be looked upon today as not only the means of advertisement but indeed a service, for it is nothing more than another means of our often overlooked communications gap. The "in" thing today in discussing the breakdown in communications is really nothing other than the good old-fashioned public relations.

Let's take our children of today. I believe they are getting more than ever from both home and community and yet they remain troublesome and unhappy; in fact, they seem to appreciate this attention less. This may be nothing more than bad public relations, or as others put it, a breakdown in communications, or a generation gap. Our patients today are getting better medical care as is our community, and yet complaining more about the care; good medical care but bad public relations.

The hue and cry of the blemished-physician image is certainly not a novelty. Any serious student of history needs only to look into any time of the ancient or modern history of medicine to see that the plight is not new.

The Royal College of Physicians was chartered in 1457 in an attempt to keep the charlatan off the streets of London and return medicine to the practitioner of his time. George Bernard Shaw and Mark Twain spoke eloquently of medical care offered by their own physician and yet simultaneously decried the avaricious practitioner of their time.

The itinerant miracle practitioner, the grave digger, and the drug trafficker have even in ancient times been erroneously categorized with the practicing physician. It has required hard work and good public relations to keep our image unblemished. None of this excuses us singly or as a group from our responsibility and our right to burnish the image for the peace of mind of our patients and their protection against those whose ulterior goals are best served by our tarnished image.

The individual physician must lay to rest the old cliché, a rationalization for the cloakroom orator of the do-nothing society, "What can I do alone?" As an individual, by his manner, dress, proficiency and morality, most acutely observed by the most learned and perceptive of his society. As an individual, and by example, does he exert moral and ethical influence of awful magnitude? As an individual, is he responsible to his peers, his community, and his profession?

Legislators, clergymen, teachers, and public relations people envy the widespread and intimate influence that we can and do have on our patients and community. A moment to explain the code of professionalism, the sacredness of privileged information and the patient–physician relationship, the excellence of medical standards demanded by the Internist, the need for professional control over medical legislation, the proper role of the medical society in the political arena—this is not an abuse of our intimate relation, but rather our obligation to those who seek our learned opinion.

In a political sphere our legislators seek the advice of their constituents in matters of technical expertise of every type. Again, this is the obligation of the physician to assist his legislator by rational, expert, effective, and positive advice and persuasion.

By last count our congressman in Washington received anywhere from 1500 to 2000 pieces of legislation each year with medical implications of varying importance—frequently of such technical and terrible complexity as to confuse even us. His legal background, without our assistance, is often not enough to enable him to make the proper decision. Our organized lobby serves as a poor substitute for the personal relationship we may have with our legislator.

Another, probably most effective, public relations job we can do as an individual is to assert ourselves and become involved in church, community, political, educational, and neighborhood organizations where we can exert our influence and protect our families and profession.

Besides our individual influence, we have an opportunity and obligation to become involved via our component national societies in determining the political and moral direction of our profession. Our American Medical Political Action Committee and our American Society of Internal Medicine have belatedly established a political expertise and influence in manners affecting our constituents, the patients. The American Society of Internal Medicine is a responsible and responsive spokesman for the Internist and his ongoing struggle for survival, professionalism, and guaranteed quality to the patient. This is one of many professional organizations engaged in similar activity.

The American Medical Political Action Committee is now the third most influential political organization in this country behind the Democratic and Republican parties. This fledgling organization with vigor and responsibility has entered, in a bipartisan spirit, into every aspect of politics.

Legislative revue, political education, review of candidates and candidate support, as well as liaison with other professional organizations, legislators, industry and labor unions, has left its mark. This is not a right but an obligation of every physician, individually and collectively, to enter into the political arena. Singly and jointly we protect our constituents—our peer and patient. This is our legacy.—GREGORY INDA, MD, Chairman of the Public Relations Committee, Wisconsin Society of Internal Medicine □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Questions Editorial Policy

TO: V. S. FALK, MD, *Medical Editor*—I would like to take exception to the inclusion of the write-up of the Cardiovascular Center at Milwaukee Children's Hospital in the January issue of the *Wisconsin Medical Journal* under the guise of its being a scientific article. This same information has been put out in the form of a brochure to all physicians in the state of Wisconsin and has also come out in the same form in a mailing in Wisconsin Heart Association envelopes. This article is out and out advertising, and I am sure that if any completely private institution in the state attempted to have this published, we would be severely censured.

There are three other areas in the state which can claim the same capabilities as those written up by Dr. Friedberg, and I am sure that Dr. Levy at the University of Wisconsin and Dr. Van Elston at Gundersen Clinic must feel as I do about this. I feel that part of my reaction is due to the fact that certainly at the Gundersen Clinic and the Marshfield Clinic, we have established these programs over many years through our own efforts with no state or federal funding, and without money from the Wisconsin Regional Medical Program which supposedly was for the establishment of patient services and not for the purchase of equipment for catheterization laboratories, etc. On this basis, attempts to continue in the practice of private medicine and establish areas of excellence would appear to be getting short shrift. Perhaps the above-mentioned institutions should request "equal advertising time" in the *Journal*.

GEORGE G. GRIESE, MD
Marshfield, Wisconsin

TO: GEORGE G. GRIESE, MD—Your letter of February 8 was received. I am sorry to learn that you were distressed by the publication of the announcement of the services offered by the Pediatric Cardiovascular Center of Wisconsin. It was not published as a scientific paper, and no scientific material is ever included in the annual "Blue Book" issue.

I'm quite certain that the pages of the *Wisconsin Medical Journal* have never been denied the Marshfield Clinic, or any of the institutions you enumerated, for the publication of announcements or programs emanating there.

The staff of the *Journal* was not aware, of course, that a brochure with similar information was being circularized to all Wisconsin physicians.

Your letter, along with any others that might be generated by this situation, will be published in an early issue of the *Wisconsin Medical Journal*.

V. S. FALK, MD
Edgerton, Wisconsin

Advocates "Teacher Corps"

TO: THE EDITOR—Dr. Wilson Weisel, in his presidential address to the Wisconsin Surgical Society, listed the problems of surgeons, and it would seem that many of them were similar to problems of physicians in general. Inability to keep up with medical advances, and difficulty in obtaining necessary relief so that additional training was possible seemed to head the list. It was suggested that physicians improve their image, increase postgraduate education, and promote teaching.

The President of the State Medical Society, Dr. Gerald Derus, thought that if Wisconsin physicians would agree to travel to earthquake-torn Nicaragua to help out, they should be able to form a "peace corps" which could give aid and support to many needy areas in Wisconsin.

Since many of our rural physicians have difficulty in obtaining relief, since many are unable to attend medical meetings or continuation of education courses or even to have meaningful staff meetings, could there not be formed a "teacher corps?" The "teacher corps" would form a nucleus of physicians which would go into the rural area hospitals at the request of the physicians. The rural area to be served could be represented by the State Medical Society's councilor district or the State comprehensive health planning area. The physicians forming the "teacher corps" would be volunteers from the same area. An abbreviated subject list to be covered could be: Clinical Pathological Conferences, Pseudo-grand Rounds, Nursing Education, Training Ambulance Attendants, and Specialty Conferences.

It may be more feasible for the rural physician to travel to the urban hospital for additional information, but past experience has shown that this is done infrequently, and the reason given is lack of time

and coverage. The "teacher corps" could circumvent this and, in addition, improve the physician image, promote teaching, and update medical information.

CHARLES APRAHAMIAN, MD
Black River Falls

TO: CHARLES APRAHAMIAN, MD—Your letter was presented to the Commission on Scientific Medicine. In March the House of Delegates changed the bylaws to read "The Commission on Scientific Medicine shall study, develop, and present programs of postgraduate and continuing education for the membership through the State and component societies and in such other ways as it may find feasible. It shall serve as the Society's coordinating body with similar education programs for physicians and allied health personnel in cooperation with the medical schools in Wisconsin and other governmental and voluntary organizations having a proper interest in this field. It shall assist the specialty societies in their postgraduate and continuing education endeavors. It shall work with the Society's peer review mechanism to influence self-assessment and self-improvement through scientific programs among the members of the Society."

For many years the State Medical Society sponsored a touring faculty which presented all day sessions at several centers around the state. Initially these courses were very popular but were eventually discontinued because of lack of interest and because of numerous other programs which had been instituted.

The Department of Postgraduate Medical Education of the University of Wisconsin has several current programs which would be helpful in bringing programs to your own hospital. One of these is the Telephone/Radio conference, a program which has been going on for several years throughout the state. Another is the Visiting Professor Service in which the visiting professor spends a full 24 hours at your hospital. Other in-hospital programs are the In-Service Program Review and the Therapeutic Criteria Review. Circuit teaching courses are also available, although these are usually for a region or area rather than for an individual hospital.

Many hospitals in the state have arranged their own visiting professor or symposium days outside of the University program. For example, here at Edgerton where the hospital is probably comparable to yours in Black River Falls, we have had a Visiting Professor at least once a year for the past ten years. The usual format is to have a "wet clinic", or hospital rounds, in the morning followed by a discussion of the patients seen and eventually by a lecture on the subject that has been previously selected. The staff members from the hospitals of neighboring cities are also invited to attend.

Both the State Medical Society and the AMA are studying and implementing Quality of Care Reviews and Continuing Medical Education. It is my feeling that within the next few years you will be inundated with programs of continuing medical education. As a matter of fact, several state boards of licensure have already enacted continuing educational laws.

V. S. FALK, MD, *Medical Editor*
Edgerton

Renowned Physicians Book

TO: THE EDITOR—I am editing a book on renowned and notable physicians and their faith.

I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler and Sir William Fleming; however, the notable physicians could still be alive.

Anyone interested in this project or who would suggest renowned physicians to write about may contact me at the following address:

CLAUDE A. FRAZIER, MD
4-C Doctor's Park
Asheville, NC 28801 □

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HOW THE
State Medical Society of Wisconsin
SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use, and to serve. To benefit fully from membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the sixth in a series of articles explaining State Medical Society organization and activities.

State Society Activities Benefit Members and Public

MANY OF THE State Medical Society activities discussed previously have obvious direct benefit for the public. Public education, health careers information, scholarships, and administration of health-care payment programs are some examples of the many public service efforts of the Society.

Workmen's Compensation

An outstanding example of State Medical Society public service is the instrumental role it played in the establishment and running of state workmen's compensation. The Society helped set up a guide for rating disabilities and it organized panels of physicians who treat employees under the Workmen's Compensation Act. This "Open Panel System" gives Wisconsin workmen the opportunity to secure virtual free choice of physicians.

The State Medical Society encourages physicians to participate in this program. A participating physician agrees to furnish the necessary medical reports and submit any disputes to joint medical society–insurance carrier adjudication. The full resources of the Society are on tap for the settlement of problems involving insurance carriers and the Workmen's Compensation program.

Committee on Grievances

Another State Medical Society public service is offered by its Committee on Grievances. This provides a facility to which the public may bring its problems, its complaints, and its "gripes"—either real or imagined—concerning an individual physician, physicians as a profession, or the medical-care situation in a particular area.

The Committee considers many matters during the course of a year, in addition to those complaints and problems handled by county societies. Its work involves detailed and deliberate case study, interviews, investigation, advice, and discipline of physicians of all ages and types of practice when necessary.

The State Medical Society's Committee on State Departments expends considerable efforts through its ten divisions in dealing with problems of handicapped children, aging, alcoholism-addiction, maternal and child welfare, nervous and mental diseases, chest diseases, school health, ear–nose–throat, rehabilitation, and vision. Each division works with governmental and voluntary groups handling similar problems; acts as a liaison between county medical societies and the American Medical Association in these areas; reviews treatment and information available to the public; and considers pertinent legislation.

Commission on Public Policy

An important duty of the State Medical Society is its representation of the medical profession before the State Legislature and Congress. The Society offers lawmakers facts about the health sciences, evaluation of health problems, and recommendations on translating new medical knowledge and developments into laws for improving and safeguarding public health.

The Society's Commission on Public Policy and staff conduct long and detailed investigations into significant public health problems between

The popular "March of Medicine" radio series, featuring Dr. H. Kent Tenney (left) and Karl Schmidt has been on the air since 1945. The State Medical Society cooperates with WHA, the University of Wisconsin station, to broadcast the weekly health program and distribute it to 35 Wisconsin radio stations. Dr. Tenney, a past president of the Society, is in his 14th year with the program.

sessions in order to present the Legislature with the profession's best judgment for their solution. Every one of the thousand or more bills introduced in each session of the State Legislature is carefully scrutinized. Committee members, staff, and legal counsel collect evidence, arrange appearances, and testify before legislative committees. Examples of the Society's efforts include the establishment of the State Board of Health, medical licensing laws, the University of Wisconsin Medical School, regulations permitting operation of voluntary prepaid health insurance plans, laws protecting the public from quackery and cultism, and the like.

The Public Policy Commission advises the State Medical Society's Council and House of Delegates on the position the Society should take on legislation. Its actions are subject to Council and House approval and must be taken within the framework of policy laid down by them. The entire membership of the Society is kept advised of the general content of all legislation and special efforts are made to inform county officers and learn the feelings of individual members.

Public Information

Legal, social, and economic developments in health care are reported and interpreted for State Medical Society members and many other readers of the Society's official publication, the *Wisconsin Medical Journal*. It contains a monthly "Green Sheet" of socio-economic medical news as well as special sections from agencies and interests concerned with medicine and public health. The *Journal's* January issue—the "Blue Book"—is an annual guide for physicians and others on health-related laws and issues.

In addition to articles published in the *Medical Journal*, the State Medical Society also issues periodic news releases to keep the public informed of Society activities, to alert them to special health problems, and to tell the story of medicine's progress.

Its weekly "March of Medicine" radio program is produced on tape by the Society and presented as a public service by 37 radio stations. The 15-minute program provides the public with sound health advice on common problems and urges listeners to "see your family doctor" regularly. □

Special Report

U100 Insulin: A New Era in Diabetes Mellitus Therapy

Reprinted from DIABETES, the Journal of the American Diabetes Association, July, 1972, vol. 21, no. 7, pg. 832

Within several months U100 insulin will be made available in the United States and Canada by manufacturers of insulin for the treatment of patients who have diabetes mellitus. At the same time U100 disposable syringes and reusable syringes capable of accurately delivering dosages over the entire range needed in both children and adults will be introduced. This advancement in a modality of the therapy of diabetes is the realization of a long-held goal of the American Diabetes Association made possible through the results of research and the cooperation of industry. The final goal is general usage of U100 insulin and the discontinuation of the usage of U40 and U80 preparations and the corresponding syringes at the earliest possible date.

U100 insulin will have significant advantages. With but this single concentration available and with insulin syringes marked with only a U100 scale, the frequency of errors in dosage should be reduced. Additional advantages will result from the compatibility of U100 with the decimal system. U100 insulin will contain 100 units per milliliter and will be available in the usual forms—rapid, intermediate and long acting. Compared unit for unit, the same forms of U100, U80 and U40 insulin are equipotent. For example, 10 units of U100 Lente insulin lowers blood glucose to the same degree as 10 units of U40 Lente insulin, whether administered to patients already being treated with insulin or to patients being treated with insulin for the first time.

When U100 is introduced, the preparations which patients are using now will continue to be available for a reasonable period of time so as to permit adequate education of patients and physicians. It is hoped that physicians will inform themselves concerning this new preparation and actively will assist their patients to secure the benefits of this advancement in the treatment of diabetes mellitus.

The above statement was prepared by the Committee on the Use of Therapeutic Agents of the American Diabetes Association and was adopted by the Association's Board of Directors June 23, 1972, upon the recommendation of its Committee on Scientific Affairs.

☐ Andre J. Lebrun, MD: *I was prompted to write this article by the fact that many doctors in Milwaukee are refusing to give smallpox vaccinations to nursing students. It must be noted that smallpox vaccination is a requirement for the nursing student that has not been removed and should not be. Not only nursing students should be vaccinated but also all hospital personnel. I think that it is the responsibility of the physician and the hospital administrator to promote and even require adequate smallpox vaccination for all the personnel for whom there are no medical contraindications.*

☐ Medical Editor: *The Health Minister of Bangladesh reported that 3,000 persons had died of smallpox in that country in the first three months of 1973. He further stated that the epidemic is now up to 250 cases daily. The World Health Organization has 20,000 workers in a vaccination campaign. (From Associated Press)*

ANDRE J. LEBRUN, MD, DPH, DTM
Milwaukee, Wisconsin

Are We Really Safe from Smallpox?

Not quite yet! This is why!

On September 25, 1971, the U.S. Public Health Service released the recommendation on smallpox vaccination formulated by its Advisory Committee on Immunization Practices (ACIP) (*Morbidity and Mortality Report,* Vol. 20, No. 38, Sept. 25, 1971).

The public at large paid much attention to the following statement: "It (ACIP) believes that the risk of smallpox in the United States is so small that the practice of *routine* smallpox vaccination is no longer indicated in this country." (My emphasis).

Unfortunately, even physicians gave much less attention to the immediately following sentence which states:

"The Committee believes that public health efforts should be devoted to assuring adequate *immunization of all personnel involved in health services* and of all travelers to and from continents where smallpox has not been eradicated." (My emphasis).

The same issue of the MMWR analyzing the risks and benefits resulting from smallpox vaccination in the United States says:

"Vaccination should routinely be required only of people at special risk; i.e., travelers to and from continents where smallpox has not been eradicated, and *health service personnel* who come into contact with patients." (My emphasis).

The European experience has clearly established that the chief site of smallpox transmission in nonendemic areas is the hospital.

In the past two decades, Europe has experienced 51 importations of smallpox. The analysis of the data available in 40 importations shows that 610 cases of secondary cases resulted from these importations, 313 cases (51%) were acquired in the hospital, among them there were 32 physicians, 41 nurses, and 50 other health personnel.

The first cases were invariably returning nationals from areas where the disease is still endemic. It must be kept in mind that in the jet age an infected person could come back to the United States and develop the disease up to about 10–12 days after being back in his community. Since the level of suspicion for smallpox is understandably very low in this country and since very few physicians would be able to recognize a mild form of the disease, there is a high probability that a sick person, when hospitalized, would have a chance to contaminate a few other persons before being recognized as a smallpox case and properly isolated.

In Meschede (Germany) a case which was promptly recognized and isolated on the second day of the disease, nevertheless resulted in 19 additional cases, three of which (with one death) in the nursing staff. Let us note incidentally that the disease was, in 17 cases, probably transmitted by air without direct contact with the case.

It is obvious that if the population at large is not to be vaccinated anymore, the first line of defense and protection within the borders of the United States will be the hospital where the sick person is likely to be carried. But, it is known, from a survey made in 1962 in six major hospitals of the country, that as much as 75% of their employees (the actual range was from 86% to 50%) had not been vaccinated within the previous three years.

Doctor Lebrun is Associate Professor, Department of Environmental Medicine, Medical College of Wisconsin, Milwaukee.

Reprint requests to: Andre J. Lebrun, Allen–Bradley Medical Science Laboratory, 8700 West Wisconsin Ave., Milwaukee, Wis. 53226.

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This shows that an important safety gap has to be plugged if the overall population of the country wants to enjoy freedom from vaccination inconveniences as well as freedom from smallpox.

The recommendation of the ACIP to abandon non-selective vaccination is based, among other factors, on the fact that smallpox seems to decrease on a worldwide basis.

BUT the question is: how accurate and reliable is the reporting? For instance, some African countries do not report any cases of smallpox, although they have been endemic for years and have not conducted any particular program of eradication. The uncertainty of the reporting procedures is further illustrated by the fact that in 1970 Ethiopia reported 722 cases, whereas, after surveillance activities were instituted, 25,372 cases were reported in 1971. In 1972, whereas less cases were reported from Africa, the disease was on the increase in the Indian subcontinent. Altogether, overall reported cases increased by 38% over the same period of 1971. The cholera pandemic has shown that when a disease is rare enough in a given country and frightening enough, there is certain reluctance and certain procrastination to admit its existence lest it hurt the tourism business in particular. We may again see this situation occur when smallpox will have been reduced to such a low level that it will be a stigma to acknowledge case(s) in a country.

ANOTHER unknown is the potentially negative impact on those smallpox eradication programs of a reduced U.S. foreign aid budget; indeed most of those programs in developing areas are financed by the U. S. A. and the money is now drying out.

Surveillance at the U. S. A. borders also offers some weakness as illustrated by the following incident. On December 18, 1971, the City of Milwaukee Health Department was informed that a city resident had entered the country through New York without any valid certificate of vaccination on December 16, 1971. Since this traveler had left India (a perennial endemic area) on December 14, the City Health Department was requested, according to the present health policy, to keep this person under medical surveillance for the duration of the incubation period of the disease. But it was impossible to find or locate this traveler. He eventually responded to multiple messages the last day of the surveillance period when he came back from a vacation in Florida where he had flown directly from New York. Thus, had he been infected he could have easily transmitted the disease in Florida while the USPHS thought he was under surveillance in Milwaukee.

Another item of interest is that on two different occasions when the City Health Department had to replenish its stock of vaccine for international travelers, it took many telephone calls across the country to many manufacturers and unusual difficulties and delays before getting the vaccine. The implication is that in case of an emergency there might be unforeseen delays in carrying on an extensive vaccination coverage of large groups of population and this could result in a more extensive outbreak than warranted.

Referring to a certain degree of polio resurgence, John Witte, MD of the USPHS Center for Disease Control recently said: "It's very easy to get somewhat cavalier when you haven't seen a case of polio for 10 or 15 years, but immunization is still a very, very important thing."

SIMILAR complacency has also led to a resurgence of diphtheria. Similar complacency could lead to similar resurgence of smallpox if we do not plug the gap that the present policy opens on our first line of defense, i.e., in the hospital.

The risk of importing smallpox is admittedly small but it is a very real one. And in evaluating it one should be extremely careful not to fall into the specious trap of blindly using statistical averages.

AUTHOR'S NOTE: *Since the submission of this paper for publication (March 27, 1973), a small outbreak occurred in England. A laboratory technician was infected at work, she had a mild form of the disease which was not diagnosed at first. On the general ward of the hospital where she was treated until the true diagnosis was made, she infected a couple who was visiting a patient in a bed next to her. Those two persons died from the disease. An additional case in the nurse who took care of those two persons was found. The nurse had a history of vaccination in childhood and a subsequent vaccination at an unknown time; because she had had close contact with the contaminated persons, she was again vaccinated. This nurse came down with a very slight case of the disease.*

If indeed, based on European experience it is *statistically* valid to say "the United States would have to have two to four smallpox importations a year to equal the annual deaths (4 to 11) that result from our current vaccination policies," the truth of the matter is that in 1972 one single importation in Yugoslavia resulted in 173 cases (54 in the hospitals) and 34 deaths.

It must be noted that this catastrophe occurred in a country which had not had a case for 42 years and where the level of immunity of the population at large is estimated at 60%, whereas in the U.S.A. it is estimated at about 20%.

THE importation of one case of smallpox is an ever present possibility and we have been lucky so far. The only and most logical protection in the absence of overall protection of the population is the building of a strong protection where the first case is most likely to show up. This protection should be imposed by appropriate regulations dealing with the licensing of some professions and the accreditation of the hospitals.

It seems, therefore, extremely important that adequate vaccination be required as soon as possible from that portion of the population which is more likely to come into initial contact with a possible case of smallpox, and its infectious belongings. This portion of the population includes: ambulance drivers, all personnel on the payroll of every hospital, all physicians, all medical and nursing students, and morticians.

Of course, medical judgment has to be exercised and genuine medical contraindication should not be cause for dismissal or for not hiring an employee in normal circumstances. However, should a case of smallpox occur, non-vaccinated persons should be kept away from the patient and their status should be at once reviewed by their personal physician, weighing the risk of contracting the disease against the risk resulting from vaccination in the new unusual circumstances.

It should be also underlined that the risks of vaccination are attached to the primary vaccinations and to the younger ages. Also it must be noted that a careful medical history of the person to be vaccinated and of his family should prevent most of the usual complications by strictly adhering to the USPHS guidelines on contraindications.

The risk of smallpox introduction in the country is small but the disease is very highly contagious. A few years ago an infected Pakistani traveler transmitted his infection to a German citizen during a stopover at the Dusseldorf airport without any direct contact as they were traveling on different planes.

Hospital personnel by their function will be in very close contact with an infected, but most likely undiagnosed patient. Let us not wait for an outbreak to plug the gaping weakness of our defense against smallpox. Let everyone of us promote smallpox vaccination in the hospitals where he works for our protection and that of the public. □

SECTION OPHTHALMOLOGY

JUNE 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DOCTOR SCHULTZ NAMED TO NATIONAL POST

Richard O. Schultz, MD, professor and chairman, Department of Ophthalmology, Medical College of Wisconsin, Milwaukee, recently was elected to the six-man Board of Trustees of the Association of University Professors of Ophthalmology. The association is comprised of all department chairmen of ophthalmology in medical schools in the United States.

COMMITTEE ON ADMINISTRATION

The committee to study the administration of the Section on Ophthalmology met May 16 in Milwaukee. Those present were MDs Herbert R. Giller, committee chairman, Harry A. Easom, and Donald E. Chisholm, Milwaukee; Jerome G. Kadell, James C. Allen, and Elmer E. Johnson, Madison; and Robert W. Pointer, Sheboygan; and Mr. H. B. Maroney, Madison, assistant secretary of the State Medical Society of Wisconsin.

This committee recommended to the Executive Committee of the Section on Ophthalmology that a part-time administrative secretary be hired and the members of the Section be assessed a mandatory $50 a year in addition to the regular State Medical Society dues. Before this can take effect, it must be approved by the Executive Committee of the Section on Ophthalmology.

The committee urges Section members to express their opinions of this proposal to James C. Allen, MD (Section Chairman), Eye Clinic, University Hospitals, Madison, Wis. 53706.

RETINOSCOPE INVENTOR DIES

Jack C. Copeland, OD, age 73, died March 24, 1973. He will be remembered for the streak retinoscope he discovered by observing the change in the light of a spot retinoscope after he dropped it on the floor and distorted the light bulb filament. He worked for Bausch and Lomb from 1927 to 1965 when he joined the faculty of the Medical College of Wisconsin.

DATES TO REMEMBER

Oct. 6–7: Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology Fall Meeting, Downtowner Motel, Green Bay. Inquiries to: John Ottum, MD, Green Bay, President. □

SPECIAL

The Greater Marshfield Community Health Plan—A Community Experiment

RUSSELL F. LEWIS, MD
Marshfield, Wisconsin

On March 1, 1971, the first group of participants started receiving health care under the Greater Marshfield Community Health Plan (GMCHP), a prepaid medical care program jointly sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Wisconsin Blue Cross and Surgical Care Blue Shield of Milwaukee. Approximately one year of negotiation went into preparation of the plan.

Our initial interest was stimulated by a strong belief that public opinion was forcing the federal government to establish new pathways for accessibility of care and to attempt control of the increasing cost of medical care. We believed that most prepaid programs, health maintenance organizations, and other proposed solutions did not meet what the American public is demanding, namely, total comprehensive health care at reasonable cost to every citizen regardless of income, geographic location, or state of health.

Our first objective was to establish the cost of high quality medical care in this type of program in rural Wisconsin, not to determine whether this was a better means of delivering health care services. Our second objective was to try making the same comprehensive care available to all citizens within our area. This report is intended to outline what the Greater Marshfield Community Health Plan is, give some historical background, report some of our findings during the first 16 months of operation, and comment on our changing philosophies and objectives.

Background

Central Wisconsin physicians were encouraged in January 1968 by (at that time) Congressman Melvin R. Laird, ranking Republican member of the Health Subcommittee of the House Appropriations Committee, to do something positive to meet health care problems. Mr. Laird contended that public pressure was so great that Congress would be compelled to enact sweeping health reform measures, probably by 1972 but certainly no later than 1975. He and we were concerned that background information being utilized in Washington had been accumulated primarily from the Kaiser, HIP, and other plans, the only sources of adequate statistical data. However, we felt that these groups were selective and not representative of the population area they served. This and other factors caused us to question whether the statistics were meaningful in our context.

Our interest led to meetings with two Wisconsin companies in our area, Employers Mutual Insurance Company of Wausau and Sentry Insurance Company of Stevens Point, to discuss proposals that would provide the entire population of our area with an acceptable comprehensive plan. Later, Wisconsin Physicians Service (WPS Blue Shield) joined the discussions. Originally we involved the physicians from Marshfield, Wisconsin Rapids, Stevens Point, and Wausau. After a series of meetings and a trip to Washington, the Department of Health, Education, and Welfare suggested a survey in our area, and the Comprehensive Health Planning group was selected. Meanwhile, the Office of Economic Opportunity (OEO) asked to be involved in the survey. This was cleared with Washington and, in the summer of 1968, OEO canvassed households in five Central Wisconsin counties. The survey was done by the National Opinion Research Corporation of Chicago and, although it was concluded in late 1968, the data became available to us in late 1969. The original HEW survey was contracted to the Rosenfeld firm of New York and was completed in early 1971. Both studies involved the same five counties but were totally different in scope.

During the latter half of 1968 and most of 1969, it became apparent that we were just talking about a better insurance program at a higher premium. We physicians were still insisting on fee for service and free choice of physician. This made innovation difficult and, despite efforts of the insurance companies and some of the physicians, the program lacked sufficient stimulus to keep going.

About three years ago officials of the Wisconsin Blue Cross volunteered their concern about the impact of Kennedy-type proposals in Washington. They realized the necessity for the private sector, represented by groups like theirs, to prove their value in the health-care field or, perhaps go out of existence. They suggested an experimental prepaid program to

From the Marshfield Clinic, Marshfield, Wisconsin.
Reprint requests to: Marshfield Clinic Foundation, 510 North St. Joseph Ave., Marshfield, Wis. 54449.
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prove their capabilities and to obtain some experience. Because no other physicians practice in Marshfield, we Clinic physicians believed that we could retain our original objectives and yet conduct a meaningful experiment without creating a problem of competition.

The Marshfield Clinic at that time was a multispecialty group of 102 physicians representing virtually all specialties and having had a salary philosophy of equal distribution since 1954. Located in rural central Wisconsin, the city of Marshfield is a community of 15,800 people having a slow but steady growth. We are fortunate to have St. Joseph's Hospital, a well equipped modern facility with 416 beds. Only three active physicians on the Hospital staff are not members of the Clinic. They are based in Colby, a town of 1,500 people 20 miles from Marshfield. The Marshfield Clinic receives referrals from much of northern Wisconsin and upper Michigan. The population within a 15-mile radius of Marshfield is about 35,000, contributes about 20% of total Clinic income and represents a minimal risk, even if a large number should enroll in the plan.

Establishing the Plan

The program was designed to provide total coverage for every person enrolled. Wisconsin Blue Cross and Surgical Care Blue Shield accepted our ideas even though they were not always actuarially sound. The rate structure was developed jointly and was limited by what the insurance company deemed was marketable. We attempted to avoid the "catches" and exclusions so familiar to patient and doctor alike in the average insurance plan. We insisted that we try to enroll the entire population rather than just predictably healthy and productive people.

We believed the coverage adequate but considered the cost out of reach of most families having incomes less than $8,000 a year. To help such families, we went to Washington and proposed an experimental federal subsidy on a sliding scale to support the economically disadvantaged. Thanks to help from Dr. Paul Ellwood, who had just originated the health maintenance organization (HMO) concept, our reception was cordial but, in the absence of specific legislation, received no funding.

A second visit in September resulted in more concrete suggestions, and we began to formulate the specific information requested. By the time this was completed, the people in Washington had been transferred; and we decided that we in Marshfield had neither the capability nor the time to do what was necessary to obtain federal aid. Therefore, we employed a consulting firm that chose to approach OEO. Unfortunately, our proposal was not accepted.

Since that time we have been very fortunate in securing a grant from the Family Health Center Program in HEW to which we applied in April 1972. In June, we were awarded slightly more than $500,000, renewable each year for three years, to help subsidize on a sliding scale those families with annual incomes of less than $7,000. Currently we are trying to arrange the details and implement this program as an integral part of the Greater Marshfield Community Health Plan.

The Plan

Provisions of the Greater Marshfield Community Health Plan:

1. All outpatient Clinic services in full including equipment, medication, supplies, and professional services rendered by physicians and paramedical personnel;
2. Full outpatient Hospital services and 365 consecutive days of inpatient Hospital care per admission including full allowance for semiprivate room and 100% of all miscellaneous Hospital services;
3. Care in an approved skilled nursing facility for convalescent and long-term illness, if such services will contribute to the participant's recovery from the condition, disease, or ailment responsible for the hospitalization;
4. Services provided by home-visiting nurses under the direction of Clinic physicians;
5. Emergency out-of-area care in full at reasonable and customary charges;
6. Specialized care not available from the Clinic or Hospital if such care is deemed necessary by a Clinic physician and is based on direct referral from him;
7. Psychiatric care for up to 70 days per period of disability in Hospital, up to 10 Clinic visits for each period of disability, and renewal of coverage after 90 days;
8. Coverage from birth until marriage through the calendar year of age 19 or, if full-time students, through the calendar year of age 25; and
9. Coverage of totally and permanently disabled dependents without age limit.

Exclusions of the Greater Marshfield Community Health Plan:

1. Dental services other than those provided by the Clinic's oral surgeons;
2. Outpatient drugs;
3. Services covered by Workmen's Compensation of Employer Liability Law;
4. Care of tuberculosis after diagnosis;
5. Services of blood donor and blood plasma;
6. Services provided or available under government law;

7. Eye glasses, artificial limbs, and cosmetic surgery (except for trauma or birth defects);
8. Ambulance service;
9. Some examinations for employment, insurance coverage, and the like; and
10. Care rendered by an optometrist or podiatrist outside of the Clinic.

During the first enrollment, all waiting provisions were waived. During the second enrollment, from November 1 to January 1, 1972, a wait of 270 days for maternity care was in effect except in the case of prematurity or existing maternity coverage by another group plan.

Financial Aspects of the Plan

Originally the Clinic received $4.86 as monthly capitation for each participant. The Hospital preferred an allowance per diem for inpatient care and compensation for care in the emergency room. Funds were allocated for out-of-area hospital and physician services at the usual and customary fees for illness or accident outside of our service area. Provision also was made for referral of patients out of the area for services not available in Marshfield. Blue Cross received administrative expenses and budgeted equal amounts for marketing and administration. These were the Plan's original allocations:

Clinic	$ 4.86
Hospital	$ 6.65*
Blue Cross	$ 1.00
Out-of-Area Services	$ .69
Referred Out-of-Area	$ .26
Total	$13.46 per person

* Equivalent to $71 per day plus emergency room charges

The average family size in our area is 3.7 individuals and this multiplied by $13.46 yielded a monthly premium of $49.80 per family. The individual monthly premium was arbitrarily set at $17, too low in retrospect. The Hospital subcontracted for nursing-home care (excluding custodial care) on a 2:1 basis and home-nursing service on a 5:1 basis.

Initially we decided that, if we did not utilize the calculated hospital services, the surplus would be applied to any loss sustained by any partner. Surpluses beyond that would be divided 50% to the Clinic, 25% to St. Joseph's Hospital, and 25% to Blue Cross/Blue Shield. The latter would use their portion of surplus to recover their expense of the developmental program. Any excess beyond that would stay within the community or the Plan. If the money obtained from the original contract did not cover rendered services, it was agreed contractually that this could be recovered in later years.

Enrollees

The first group, about 1500, was the Marshfield Clinic physicians and employees and their families who joined March 1, 1971. St. Joseph's Hospital employees and families, about 1600, became members April 1. Open enrollment lasted until July 1, 1971, during which time a sincere effort was made by Blue Cross to contact all groups and every person within the selected geographic area. Anyone under 65 could join if he could pay the premium. There were no waivers or exclusions for pre-existing conditions. The second open enrollment lasted from November 1, 1971, to January 1, 1972. Enrollment is closed periodically to prevent individuals from delaying enrollment until illness occurs. The third open enrollment lasted from May 1, 1972, to July 1, 1972.

Some Features of the Plan

First dollar coverage; no deductibles. This was based on previous experience convincing us that deductibles would have to be substantial before they would affect the utilization. In our experience, people in our area do not like to come to the Clinic or Hospital unnecessarily, so we started with only minor worries about over-utilization. Also, in our experience, cost of collecting deductibles made their use unfeasible.

Free choice of physician within the Clinic and the area. Patients calling or coming to the Clinic for an appointment were handled just as they had been before the Plan. This meant free choice of physician. One of our first and most important experiences reaffirmed our fundamental belief that patients want free choice. This is illustrated by the community of Spencer and farm areas between Marshfield and Colby where a three-man group has a large office practice and is on the St. Joseph's Hospital active medical staff. Many people preferred the Colby Clinic for their primary care but came to the Marshfield Clinic for what they considered more complicated medical needs. As originally outlined, the Plan would not have allowed them to utilize the Colby Clinic without paying separate fees for service. Because of our long-standing association with these physicians, it seemed simpler to reimburse them on a fee-for-service basis using their usual and customary charges.

This procedure was adopted and subscribers now have a choice between the Marshfield Clinic and the Colby Clinic. Once a month the Colby Clinic bills the Marshfield Clinic for services rendered

and is paid out of the capitation received by the Marshfield Clinic. Since that time we have made a similar agreement with Dr. Frederick Kroeplin, a general practitioner with an office practice in Stratford, and with Dr. Robert Capling, an osteopathic physician with an office practice in Pittsville, 17 miles south of Marshfield. These men have been on the hospital courtesy staff for some time. On July 1, 1972, Dr. Morgan Ellis, an osteopathic physician from Abbotsford, 22 miles north of Marshfield, joined the Plan, slightly expanding our geographic area.

"Anonymity" of patient. We have studiously avoided any method of conveying a patient's method of payment to the physician. Unless the patient reveals this or the physician happens to know the patient works at the Hospital or the Clinic, the physician does not know the patient's method of payment. We have stressed this because we did not want to alter the pattern of care, nor did we want to be accused of giving second-class medicine to any member of the Plan. We have made no effort to send patients to any specific physicians or to use physician assistants.

Community participation. At the suggestion of Blue Cross, a Community Committee was established once the Plan got underway. They were told that they were not to be a rubber stamp but were to advise actively. To date, after spending a good deal of time getting acquainted with the plan, deciding objectives of the Committee, establishing bylaws, and the like, they have made some excellent contributions including the shaping of some of our philosophies. We anticipate a much more important role by the Committee as we start adding other services, public relations, and the like. Currently the Committee is chaired by Dr. Norbert E. Koopman, Dean of the University of Wisconsin Center (in Marshfield) and consists of representatives from the clergy, industry, labor, farming, small communities, government agencies, and others.

Special Groups

Title 19. The State Department of Industry, Labor and Human Relations has expressed a willingness to participate in an experimental program. However, Wisconsin law forbids payment for services before they are rendered. A modification of this law was proposed in the 1972 Legislature. No one opposed it, and we anticipate passage in the 1973 session.

Title 18—Medicare. We chose to wait for passage of HR-1 and expect now to actively pursue incorporating this group in the Plan.

"The near poor." Our major disappointment to date has been failure to make the program available to people who cannot afford to enroll. As mentioned previously, the Family Health Center has just granted funds to help those people not on welfare (Title 19) but whose family incomes are $7,000 or less a year. These federal funds will pay a portion of the premium on a sliding scale. At present we are negotiating to enroll this group as regular members of the Plan so that they will receive exactly the same benefits and same care as any other Plan member. This will require a waiver in the grant, but we are optimistic. An estimated 3,000 to 5,000 individuals are in this group.

Plans for Expansion

When the program started we wanted to keep the geographic area well defined. Addition of physicians in the area did cause minimal expansion. Some participants living 35 miles from Marshfield are enrolled in the Plan through group plans of employers. Apparently some of these people have shifted their medical base from local family physicians to the Clinic in order to enjoy the financial advantage. As a result, we have discussed methods of solving this problem with some of the physicians in the nearby communities. Basically, however, we still believe that the Marshfield Clinic cannot offer primary care to people living more than 20 to 25 miles away.

Results

Financial. During the first 16 months of operation from March 1, 1971 through June 30, 1972, the Marshfield Clinic's contingent liability or loss was more than $409,000 and St. Joseph's Hospital's more than $73,000. The Clinic and Hospital loss represents the cost of delivering the care plus 4%, a concept established at the start. Had the physicians received fee-for-service for services rendered, the contingent liability would have been slightly more than $500,000. We attempted to make this figure accurate by considering uncollectable debts, reduction in administrative paper work, and the like, and discounted a considerable sum for over-utilization on the part of Clinic physicians, their families, Clinic employees, and their families. These first 16 months reestablished the fact that physicians and Clinic employees utilize medical services more than anyone else. Before the Greater Marshfield Community Health Plan, these services were free.

Because the original calculation for hospitalization was based on 0.825 days annually per person and the actual utilization was 0.732, some excess money accumulated. In addition, the out-of-area and referred-out-of-area services were less than those budgeted. These surpluses plus accumulated interest totaled about $170,000 from which the Clinic will receive about $130,000. This means that the Marsh-

field Clinic lost about $280,000 in the first 16 months. Why?

1. Obvious errors in the original calculation based on previous experience, during which time the costs of medical care increased rapidly.
2. An error in judgment by some of us physicians who publicly discussed the Plan. A family of two was enrolled for $34 (two single memberships) because this seemed logical. By the time the insurance company told us that this was not financially feasible, we felt morally committed. Blue Cross estimated that this commitment cost us approximately $108,000 during the first year of operation.
3. Enrolling anyone with a medical problem. The Plan appealed to those individuals who were sick or had large anticipated medical costs. However, despite rumors, people have not moved to Marshfield to take advantage of the Plan.
4. Large families in the Plan. The premium was based on a family size of 3.7 members per family when, in fact, the size is 4.9. This did not include the two-member families enrolled as two singles.
5. The Plan's experimental nature. No effort was made to contain costs because we wanted data to establish the maximum sum currently required for care of the greatest-risk group in our area, at least among those who could afford the premium.
6. Marshfield's typical, rural, midwest conservatism. Many groups and small industries, unions, and the like adopted the attitude of wait and see. Also, union contracts often run for two and three years, so these larger organizations with healthier people were unable to enroll initially.

Utilization

To date the computer has cumulated much information, the significance and evaluation of which are being studied by Dr. John Mitchell. We expected increased utilization in the Plan because some of the subscribers were ill from the start. Perhaps for this reason physicians did not subjectively feel that patients were over-utilizing the Plan. We divide our participants into four major groups.

1. Clinic physicians and employees.
2. Hospital employees.
3. Group participants.
4. Non-group participants (individuals who purchased their own insurance).

The Clinic group utilizes our services at a higher rate than the others. As might be expected, the non-group members are second. Many of these have been unable to get other health insurance because of pre-existing conditions, often serious, and have taken advantage of open enrollment periods to enroll. Third in utilization are the Hospital employees, and last are the members of groups.

If the Clinic's patients were grouped by method of payment, initial data seem to indicate the greatest use of outpatient facilities by Medicare patients, next by Medicaid patients, next by Greater Marshfield Community Health participants, and least by fee-for-service patients. The latter group includes those not insured as well as those in other insurance programs.

Hospital utilization has already been mentioned. It did not change materially during the first year of the Plan. Before the Plan, the state rate quoted by Blue Cross was 1.1 days annually per person. In the general area of the Plan, it was 0.825, and somewhat less in Marshfield. GMCHP participants utilized the hospital during the first 16 months at a rate of 0.732 days per person per year. The physicians and hospital made no effort to reduce hospitalization during this time.

Compared with patients not enrolled in the Plan, departmental utilization based on percentage of total fees showed only a few minor variations. Radiology and the laboratory provided 15% and 14% of services respectively, on either basis. Perhaps, the most striking feature was in Oral Surgery which represented 6% of Plan services, but less than 2% of fee-for-service. Both Pediatrics and Obstetrics/Gynecology showed slightly higher usage by Plan participants as anticipated. Cardiovascular and Thoracic Surgery represented a dramatically greater percentage of fee-for-service patients as would be expected due to the referral nature of this type of problem.

Physician Reactions

Because our situation is unique, it is difficult to obtain meaningful physician reactions. Basically we doctors have seen no change in our pattern of delivering services. We do not know which patients belong to the Plan. Patients have free choice of physician. The major reaction came at the end of the first year when it was determined that, had we charged Plan members fee-for-service, we would have received slightly more income. As might be expected, the reaction was unfavorable. However, it did not materially alter our take-home pay because we all received full annual salary plus a little more. Again, several problems were obviated by the fact that we have a group practice and an equal salary program which is not affected by a physician

taking care of patients in the Plan. It is my belief that the HMO concept, as it generally exists here and elsewhere, has not provided substantial incentive for physician involvement. The best argument for physician involvement is the continuing one, "If you don't do something about this, the Government will do something for you." Whether this philosophy is adequate or acceptable is certainly open to debate.

Patient Reactions

With very few exceptions, patient reaction to date has been highly favorable. It is significant that, to our knowledge, few left the Plan in response to our increasing the premium. Generally speaking, we believe that the Plan has produced some of our finest public relations.

New Rate Structure

When we reviewed our rate based on the first year's experience, we established a new structure starting July 1, 1972. Our comptroller computed a monthly cost of about $7.70 per person for the care rendered by the physicians and Clinic during the first 16 months. Based on this experience, increased costs, and other projections, our initial calculation would have established a monthly rate near $64 per family. Because this was believed too high by the Community Committee and the marketing group, we agreed on $56.90 monthly per family and $25.95 monthly per individual, broken down as follows:

Clinic Capitation	$ 7.50
Hospital	$ 5.84*
Referral Out-of-Area	$ .41
Blue Cross	$ .90
Total	$14.65

* Equivalent to $90 per day plus emergency room charges

A word of explanation about each of these. The capitation will be paid monthly as listed. However, in addition the Clinic has $0.46 deferred capitation per participant per month billed into the premium. This will be paid in December and July if money is available in the fund. The Hospital figures include both inpatient and outpatient care. The inpatient services are based on the first year's utilization rate of 0.732 days per patient year. If money is available in December and July, they will receive up to $0.03 per patient more per day for outpatient care. The cost of referral and out-of-area emergency services which originally accounted for $0.95 of the premium has been reduced to $0.41 based on the first year's experience with $0.03 more allotted if needed and available. The administrative charge for Blue Cross has been reduced to $0.90 and, if available, Blue Cross will receive an extra $0.10 per participant. If capitation deferred is added to the $14.65 paid, the total monthly capitation is slightly higher than that listed above, and it is this multiplied by 3.7 that established the family rate of $56.90.

We also agreed that we would no longer sell two single policies to a husband and wife. They now purchase the family program.

A very significant change in the basic concept has occurred, however. That is, we have agreed to a capitation arrangement by which we can receive up to the foregoing figures as a maximum but can recover no loss. Therefore, Hospital and Clinic now operate at a greater risk. If money is left over, it will probably be used initially to recover the losses incurred during the first 16 months of operation. Eventually, any surplus would be utilized to add more service or to stabilize the rate.

Philosophy

Government and health planners have been proposing the prepaid approach with the HMO philosophy so that the incentive will be to cut costs by providing fewer services and utilizing preventive medicine. Physicians would profit by avoiding overutilization, whereas, under the traditional fee-for-service arrangement, the incentive has been to provide more services for patients. This produces a real quandary about continuing maintenance of high quality medical care. However, it is possible that we may be able to save the patient costly duplication of diagnostic and treatment services by closer supervision.

As a referral center, we cannot afford to miss any diagnosis by ignoring the laboratory, radiology, and full consultation advantages that exist within our group. We do not identify our patients as members or non-members of the Plan. But we can identify the patient as living within our geographical service area. We believe we can avoid some costly diagnostic tests on an initial visit for people from our area since they will return if they need more medical care. Our group of physicians is so indoctrinated with the type of medicine practiced here for years that we have no major concerns about the quality of care suffering as long as we remain in control.

Having determined that we will sincerely try to accept the philosophy of prepayment and capitation, we are making a number of adjustments so that we can live and (we hope) grow with little change in our present capitation figure.

1. We will try to reduce the cost of medical care to people within our primary care area, primarily by educating our physicians to think in these terms and by reviewing hospital utilization and duration of hospital stay. We believe that the Home Nursing Service which

was not utilized during the first 16 months may provide help with this problem.

2. We will try, for what it may be worth, to educate our patients about how to use health-care services more effectively and get involved in preventive medicine, particularly immunizations, "Pap" smears, family planning, and the like. We hope to accomplish some of this by a monthly newsletter to subscribers written primarily by our physicians.

General Conclusions

We believe that the citizens of the United States today have "a right to access to good health care" as outlined. We believe it necessary for the medical profession to deliver as comprehensive total-quality care to *all* people as is possible. There must be a system that will provide accessibility of health care for all and which will ensure that the already sick and poor get adequate care. For that reason, we embarked on our prepaid capitation program as an experiment to see if it offered satisfactory alternatives. The answer is still unknown.

If we can expand our coverage to Title 18, Title 19, and the "near poor," this approach seems to have the advantage of maintaining dignity of all those enrolled by providing accessibility and equal care.

We believe that both fee-for-service and prepaid programs can be operated in a single medical setting and can be mutually beneficial to all patients. This is facilitated by group practice.

We believe it is vital to develop a peer review mechanism that will emphasize quality as an incentive as well as reducing costs.

It is difficult to reconcile the philosophy of preventive medicine as an advantage of the HMO concept; that is, our physicians and employees receiving benefit of preventive medicine for many years are the most expensive to take care of.

We believe that physicians and hospitals must get actively involved in the evolutionary process that is taking place in medicine. If they stand by as spectators or technicians, the political, governmental, and consumer forces will undoubtedly make radical changes in the delivery and financing of medical services which might not be in the best interest of our patients.

We jumped rather precipitously into our program after years of discussion but not much experience in planning. We feel we have learned a lot and, in retrospect, are happy that we proceeded early. Although we might have avoided some problems, at least we feel we are much farther ahead now than we would be, had we continued to plan in depth.

We are grateful to the Wisconsin Regional Medical Program for its help in funding a subsection within our Foundation which is studying these areas in detail and from whom will come a number of reports in the next year.

It is my belief that prepaid capitation for an area like ours can be a voluntary mechanism for providing maximum medical services to all by spreading the risk to all. This, of course, is in contrast to the history of insurance programs which have stressed taking in well people and letting the poor and ill fend for themselves. If this mechanism proves successful, I believe it may be a desirable alternative to federal control which, by and large, is less sensitive to local needs and is considerably more expensive.

It is almost impossible to acknowledge all of the other individuals who worked to get this program going and keep it in effect. We want to especially thank Mr. David Jaye and the Sisters of the Sorrowful Mother representing St. Joseph's Hospital, Mr. David Neugent and his associates from Wisconsin Blue Cross–Blue Shield for their partnership and contributions. Special mention should go to Dr. Ben Lawton, President of the Marshfield Clinic when this Plan was instituted, for his leadership, and to Dr. David Ottensmeyer, the current President, for his leadership in the modifications. Mr. Floyd Detert and Mr. Brad Larsen, former Administrator and Assistant Administrator respectively, contributed greatly in the initial phases of the planning and the establishment of our Plan. Dr. John Mitchell and Mr. Bill Murray have been responsible for many of the statistics and will be reporting more in the future. Dr. Frank Lohrenz and Dr. G. Stanley Custer also helped in this respect. Mr. James Ensign, the Clinic's new Executive Director, has taken over many aspects of the Plan. Mr. Donald Nystrom has been in charge locally at the Clinic in the administration portion. Mr. Frederick Wenzel from the Marshfield Clinic Foundation has contributed, particularly to the Family Health Center grant. Special thanks go to all of these people who helped in writing this paper, especially Dr. Gerald Porter and Mr. Albert Zimmermann. □

Discreet Diagnoses

One of every seven or eight patients examined by doctors has a drinking problem which he hides with a symptom for another illness or which doctors fail to recognize, says a team of researchers on alcoholism. Dr. David Knott, head of the Alcohol and Drug Dependence Clinic of the Tennessee Psychiatric Hospital in Memphis, said: "We're not speaking of the skid-row bum. We mean the chronic drinker who denies he has a problem and whose physician is unable or unwilling to confront him with it."—NATIONAL ENQUIRER □

SPECIAL

Disability Insurance Under Social Security

HENRY A. ANDERSON, MD
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WHENEVER A PHYSICIAN is asked to furnish a medical report in connection with a patient's claim for social security disability benefits, it's a reminder that social security is not just for the retired—it also provides important financial help for people who cannot work because of a serious illness or injury.

Currently, over 3 million men, women, and children receive social security disability checks every month because someone in the family—usually the breadwinner—is disabled. Their payments total almost $5 billion a year. In addition, more than 76 million working men and women are insured for disability benefits as a result of their earnings—wages or self-employment—under social security.

Beginning July 1, 1973, full Medicare protection will be extended to persons under age 65 who for at least 24 consecutive months have been receiving monthly social security benefits because they are disabled.

A person under 65 can receive monthly disability benefits if he has a physical or mental impairment severe enough to prevent him from doing any substantial gainful work for a year or longer. Benefit amounts based upon a person's earnings under social security range from $84.50 to $345.50 a month for the disabled worker alone, and the maximum monthly benefit for a disabled worker with a family is $620.40.

From a Small Beginning

The original Social Security Act of 1935 provided benefits only for the retired worker. It was not until 1954 when the disability "freeze" provision was added that the law gave some protection to the disabled worker. Under the freeze, years when a worker earned little or nothing because of disability were not counted against him later in deciding if he was eligible for retirement benefits, or in figuring his retirement benefit amount. To be eligible for the freeze the worker had to have a disability that was expected to be of "long-continued and indefinite" duration.

Two years later, monthly cash benefits were provided for disabled workers aged 50 to 64, and also for the disabled adult sons and daughters of retired or deceased workers if the son or daughter had been continuously disabled since childhood.

Over the years the program has been further modified. The minimum age limit of 50 for payment of benefits to disabled workers was eliminated; "long-continued and indefinite" duration was changed so that an insured worker could be eligible if his disability had lasted or could be expected to last for at least 12 months; fewer years of covered employment were required for a young worker to be insured for disability; and benefits were provided for disabled widows (between ages 50 and 60) of covered wage earners. The latest change, of course, is Medicare protection for disabled persons under 65.

Who Can Get Benefits?

Social security disability benefits can now be paid to:

A disabled worker under 65 and his family, if he has worked under social security for a certain length of time, ordinarily 5 of the 10 years preceding the onset of disability. (Special provisions apply to workers disabled by blindness allowing them to qualify with even less work under the program.) For the worker who becomes disabled before he reaches 31, the work requirement ranges down with age to as little as 1½ years.

A person continuously disabled since childhood (before age 22), if one of his parents (in some cases a grandparent) who is covered under social security retires, becomes disabled, or dies. The mother of the disabled son or daughter may also receive monthly benefits as long as she has the child in her care.

A disabled widow 50 or over, if her late husband was covered under social security, and if she meets the specified level of medical severity. This also applies to disabled dependent widowers and certain disabled surviving divorced wives.

Reporting Medical Evidence

When a patient applies for benefits, he is asked to submit medical evidence to support his claim.

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This evidence usually consists of data from the records of his treating physician, clinic, or other medical source. Our experience with the disability program in Wisconsin indicates that in about three out of five cases no further medical development is needed because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

This information may be requested on the patient's behalf by a social security office—or, more often, by the Bureau of Social Security Disability Insurance, Division of Vocational Rehabilitation, Department of Health and Social Services. This is the full name of the agency in Wisconsin that evaluates social security disability claims for Wisconsin residents. Like other state agencies throughout the country that work with Social Security in the disability insurance program, the Bureau of Social Security Disability Insurance in Wisconsin includes both physicians and trained disability examiners on its professional staff. They form a balanced team of medical and non-medical people who can handle anything from a strictly medical issue to a complete assessment of the vocational factors which bear on the disability decision.

With the assistance of our staff of reviewing physicians, we endeavor to make these requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the busy physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information available.

The evaluating physician here in the Wisconsin agency never sees the patient. He depends heavily on information supplied by the applicant's physician to assess the severity of the applicant's impairment, its expected duration and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the quality of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient for us to evaluate the claim and make a decision.

For example, if the patient experienced a myocardial infarction, we would look to the report submitted by the treating source for such information as date of occurrence, place and duration of the hospitalization, as well as results of x-rays, electrocardiograms, and other laboratory studies.

Serial ECG tracings should, whenever possible, accompany the report so that our staff of physicians may also have the benefit of reviewing this essential documentation. Equally important is the medical history, including onset of chest discomfort, relationship to effort, intensity, location, radiation, regularity, and to what extent relief is obtained by rest or medication.

If a report does not contain all the findings necessary to make a proper decision, one of our reviewing physicians may recontact the medical source. However, the additional time required may delay the patient's claim and can add up to a significant additional program expense.

The physician can help speed the decision on his patient's claim by reporting all relevant data about his medical condition as promptly as possible.

Establishing the onset date of disability—often a key factor in determining the beginning date and amount of the claimant's benefits—is frequently difficult. Therefore, it is extremely helpful if the reporting physician includes the date of each important fact or finding. To save time, he may enclose photocopies of pertinent sections of the patient's chart or of hospital or consultant's reports.

Criteria for Evaluating Disability

In making disability determinations, our agency uses medical criteria developed by the Social Security Administration to insure uniform evaluation of all applicants no matter where they live, and to help simplify and speed the decision process. These criteria were worked out with the aid of practicing physicians, major medical organizations, and SSA's Medical Advisory Committee.

Generally, a claimant who is not working can meet the social security definition of disability if he has an impairment or combination of impairments that are the same as, or medically equivalent to, any set of findings in the criteria. (This is the only way the *widow 50 or over* can qualify for disability benefits.) However, for *all other claimants* whose impairments fall short of this test, such factors as age, education, and work experience added to the functional limitations imposed by the medical condition are taken into consideration in making the disability decision.

The complete criteria, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook describes impairments in terms of specific symptoms, signs, and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer. A copy of this handbook was mailed to all physicians in Wisconsin.

We welcome any inquiries from physicians who wish to know more about the social security disability program and its policies and procedures. □

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Localization of Bleeding Vascular Lesions in the Gastrointestinal Tract

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REPEATED EPISODES of unexplained gastrointestinal bleeding with negative radiological or endoscopic findings, raise the possibility of a vascular lesion, an important cause of hemorrhage which may be difficult to identify. This report describes a technique at surgery which may determine the bleeding site, when the source arises from a lesion of the alimentary tract.

Case Report

A 60-year-old woman was admitted to the hospital in August, 1970 with a three year history of intermittent rectal bleeding. Blood was bright red, lasted for three to four days, and blood transfusion was required each time. Previous extensive evaluation for gastrointestinal bleeding including an exploratory laparotomy did not reveal the etiology or site of bleeding.

On admission hemoglobin was 8 gm/100 ml, hematocrit 20% and blood studies for hemorrhagic diathesis were negative. There were no vascular lesions on the skin or mucous membranes. Proctosigmoidoscopy, endoscopy, barium meal, small bowel follow-through, and barium enema were normal. She was given blood transfusion and an exploratory laparotomy was performed. The gastrointestinal tract from the lower esophagus to pelvic reflection was inspected. No abnormality or lesion was noted to account for recurrent bleeding. Abdomen was closed without further surgical intervention. On the eighth postoperative day she began to pass bloody stools which persisted for five days and multiple blood transfusions were required. A transfemoral, celiac, superior mesenteric and inferior mesenteric arteriogram was performed with negative results. She was discharged without the bleeding site being identified.

She was readmitted two months later for severe rectal bleeding. At surgery, a duodenotomy was first performed but no blood was seen. After the duodenotomy was closed, an opening was made in the proximal jejunum near the ligament of Treitz. A Baker tube* (Fig 1) was inserted into the lumen and the balloon was inflated filling the lumen of the bowel. It was then pulled through the entire

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* Baker Jejunostomy Catheter, Catalog No. 173-L, manufactured by C. R. Bard, Inc., Murray Hill, NJ 07974.

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Figure 1—Jejunostomy catheter (Baker tube). Balloon is inflated with 100 ml of water.

small bowel and the ileocecal valve into the cecum and the colon. This was done applying greater pressure than usual, in the hope that the balloon would cause bleeding passing over the vascular lesion. The return from the tube was clear initially, until it reached the cecum when bright red blood was seen. Each time the Baker tube was passed over the cecum the returns were bloody. On the basis of these findings, a right hemicolectomy was performed. The resected specimen revealed varices in the cecum. On microscopic sections there was increased vascularity, cystic spaces filled with red cells and atrophic mucosa with erosions overlying the lesion. The histological appearance was consistent with phlebectasia of the cecum.

She had no further bleeding episodes. The patient died of a myocardial infarction a year later and no other vascular lesions were found at autopsy.

Discussion

Vascular lesions are among the rare causes of gastrointestinal (GI) bleeding.[1-3] A high degree of suspicion usually arises in repeated episodes of GI bleeding with negative diagnostic studies, positive family history of bleeding, or in patients with hemangioma or telangiectasia of head, neck, and extremities.[4,5] The prognosis of intestinal vascular lesions is variable. Although most often asymptomatic, occult hemorrhage and low-grade iron-deficiency anemia are common sequelae. In cases of repeated massive hemorrhage, the outlook without definitive treatment is generally poor,[7] a point which emphasizes the importance of localization of the lesion.

Neterville *et al*[5] reviewed the diagnostic methods to identify the bleeding site of vascular lesions of the GI tract which include: (1) Einhorn string sign; (2) fluorescein string test; (3) operative transillumination of the gut; (4) operative endoscopy; (5) glass slide pressure of bowel wall; (6) superior mesenteric arteriography, provided that the blood loss exceeds 2 ml/hr,[6] and (7) abdominal exploration during the bleeding episode.

The technique described herein was successful in the accurate localization of an intestinal vascular lesion, which was not identified as the cause of recurrent, major episodes of bleeding by more sophisticated methods, including two exploratory laparotomies. Passage of the jejunostomy catheter over the hemangioma caused the lesion to bleed actively and thus the site of hemorrhage was identified for the appropriate surgical treatment. This may be a helpful adjunct to other methods for localization of vascular gastrointestinal malformations. It is a simple, free of complications, inexpensive procedure and a practical method to differentiate bleeding from non-bleeding lesions of the GI tract at laparotomy.

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Experimental Human Exposure to High Concentrations of Carbon Monoxide

R D STEWART, MD, MPH; J E PETERSON, PhD; T N FISHER, MD; M J HOSKA, PhD; E D BARETTA; H C DODD; A A HERRMANN, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Environ Health* 26:1–7 (Jan) 1973.

Six healthy male human volunteers were exposed to seven high carbon monoxide (CO) concentrations ranging from 1,000 ppm for ten minutes to 35,600 ppm for 45 seconds. Carbon monoxide was rapidly absorbed and the increase in percent carboxyhemoglobin (COHb) saturation in venous blood per liter of CO mixture inhaled could be accurately predicted by the equation, log (Δ% carboxyhemoglobin/liter) = 1.036 log (ppm CO inhaled) — 4.4793. The abrupt increase in carboxyhemoglobin concentration of 11.6% and 9.1% saturation in two subjects produced the immediate onset of mild frontal headache. The subject exposed to 35,600 ppm demonstrated slight sagging of the ST-segment of lead II. This occurred 20 seconds after the exposure had started and persisted for ten minutes after exposure. Neither the spontaneous nor the evoked electrical activity of the brain exhibited significant changes which could be attributed to CO exposure over the range studied. □

LAPAROSCOPY: Report of 500 Consecutive Cases

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ENDOSCOPY OF THE PERITONEAL cavity, particularly the pelvis, has changed radically over the past decade. At our institution culdoscopy was a regularly performed procedure from 1957 through 1967. Since 1968, however, it has become a rarity and has been almost completely replaced by laparoscopy. A brief review of the literature indicates that this also is true throughout the country.[1,2] This report describes our experiences with the technique in 500 consecutive patients.

Age

The vast majority of these patients were within their reproductive years (Table 1). Initially the procedure was being performed primarily for infertility problems and as a diagnostic device, so that the average age was in the mid- to late 20s; with the increasing use of laparoscopy for sterilization, the average age rose to the mid-30s. Also in the early age group it is for determination of genetic disorders; in the older age group the indication is to determine the presence or absence of malignancy. When laparoscopy is performed at the age extremes (under 20 or over 50), it is almost always for diagnostic purposes.

Sex

The vast majority of patients in this survey were female, although there were eight males. In these instances the author had been requested by his colleagues in Medicine or Surgery to evaluate the patient, usually with respect to hepatic disease or the presence of malignancy. In one male patient there was a question of leakage from a vascular graft.

Indications

The indications for laparoscopy are outlined in Table 2. A survey of the first 100 cases indicated a high percentage were being done for infertility problems, unexplained abdominal pain, and the possibility of ectopic pregnancy. As surgical techniques were introduced,[1,2] the impact of the procedure was felt more keenly in the area of sterilization by means of tubal cautery and division. In many instances there were multiple indications for the laparoscopic procedure (accounting for a total percentage above 100%).

A sterilization procedure was done in 304 cases (60%), usually with a diagnosis of multiparity and the ineffectiveness of contraception. The second-largest group related to abnormalities of the menstrual pattern. This consisted of 64 cases (13%). A third large group was under investigation for infertility, 57 cases (11%).

TABLE 1—*Age*

Age 20 or Under	*Ages 21–30*	*Ages 31–40*	*Ages 41–50*	*Age 51 or Over*
59 (12%)	215 (43%)	195 (39%)	26 (5%)	5 (1%)

TABLE 2—*Indications*

Tubal Sterilization	304	61%
With Therapeutic Abortion	6	
Repeat, with Therapeutic Abortion	1	
Infertility	57	11%
Primary	45	
Secondary	12	
Abnormal Bleeding	64	13%
Primary Amenorrhea	6	
Secondary Amenorrhea	24	
Post-Pill Amenorrhea	1	
Oligomenorrhea	26	
Dysfunctional Uterine Bleeding	7	
To Rule Out	38	8%
Sclerocystic Ovaries	5	
Ectopic Pregnancy	15	
Endometriosis	3	
Ovarian Cyst	2	
Cancer of the Ovary	4	
Gonadal Dysgenesis	1	
Liver Disease	8	
Unexplained Pelvic Pain	24	5%
Miscellaneous	33	6%
Pelvic Inflammatory Disease	7	
Pelvic Mass	23	
Previous Tubal Plastic Surgery	1	
Habitual Abortion	1	
Removal of Intrauterine Device	1	
		104%*

* Some cases had multiple indications.

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Frequent utilization of the procedure was made in ruling out the presence of intra-abdominal problems. Sclerocystic ovaries can be viewed and their presence need not be in doubt, even in the obese patient. Whereas laparoscopy was used to determine the presence of ectopic pregnancy in the earlier cases, this indication has diminished in frequency. Endometriosis[3] can be specifically diagnosed, even in its earliest phase. Ovarian cysts can be viewed directly and, if considered to be benign in a young female, punctured and evacuated.[4] Obscure cases of gonadal dysgenesis can be delineated and ovarian biopsies[5] obtained for karyotypic evaluation. For the physician plagued with patients having pelvic pain but with no specific findings on examination, it is possible to ascertain that the pelvis is free of disease and to proceed with psychosomatic treatment of these patients. Laparoscopy allows for a relatively simple "second look" in cases of suspected metastatic malignancy.

Findings

Of the 304 cases related to tubal sterilization procedures, obviously the pelves were not normal in all of these. The unusual findings were quite disparate, and not related at all to the indication for the surgery. The findings in the remainder of the 196 cases are shown in Table 3. The scope of this paper does not permit a detailed evaluation of the findings as related to the indications. Rather, they illustrate the broad scope of pelvic pathology that can be discovered or confirmed by laparoscopy.

TABLE 3—*Findings (196 cases)*

Normal Pelvis		51
Ovary		69
Anovulatory	32	
Sclerocystic	19	
Corpus Luteum	5	
Streak	5	
Adhesions	5	
Cancer	3	
Tube		40
Pelvic Inflammatory Disease	29	
Occluded	3	
Patent	1	
Ectopic	7	
Uterus		11
Intrauterine Pregnancy	1	
Fibroids	6	
Perforation	1	
Hypoplastic	2	
Absent	1	
Miscellaneous		22
Pelvic Congestion Syndrome	3	
Endometriosis	14	
Hematoperitoneum	1	
Presacral Cyst	1	
Liver Disease	3	

Fifty-one patients were found to have an entirely normal pelvis, many of them having pelvic pain as the indication for the laparoscopy. In others laparotomy was considered for a variety of reasons but was cancelled when the pelvis was found to be within the limits of normal.

The ovaries are particularly accessible for laparoscopic inspection.[6] Thirty-two (32) cases of anovulatory ovaries (a description applied to relatively small, whitish, non-scarred, non-cystic, inactive appearing ovaries) were found, primarily in relationship to secondary amenorrhea and post-pill amenorrhea. The term "sclerocystic" was utilized for the range of ovaries related to the complex syndromes of which the Stein–Leventhal syndrome is the most clear-cut. (Although the size varied, all of these ovaries were cystic, with thick, white capsules, and lacked evidence of ovulation.) The presence of streak ovaries made it a simple matter to confirm or establish the diagnosis of gonadal dysgenesis. Adhesions were most often associated with pelvic inflammatory disease. In our series, the diagnosis of carcinoma of the ovary was generally made late in the course of the disease, primarily to establish the presence of metastasis.

Tubal pathology fell into two major categories. The ectopic pregnancy could be diagnosed early (as in two cases of unruptured tubal pregnancies), or late (in which case the laparoscopy served as a paracentesis), or for pelvic inflammatory disease. If the disease process was acute, it was possible to differentiate between that and acute appendicitis. (It was also fascinating to observe the difference of tubal involvement between the two sides on occasion, with marked deformity unilaterally and nothing more than hyperemia on the opposite side.) Chronic pelvic inflammatory disease is much more evident on laparoscopy than on hysterosalpingogram,[7] and, in several cases, apparently normal tubal studies were disqualified by the finding of patent but abnormally distorted and adherent Fallopian tubes.

Observation of the uterus allowed the operators to make the diagnosis between ectopic and intrauterine gestation, to distinguish between uterine and ovarian tumors, and to make definitive diagnoses of such entities as hypoplastic and absent uteri.

Miscellaneous pelvic conditions became much more apparent on laparoscopic visualization. Very early and very late endometriosis often determine the extent of the therapy required. Hematoperitoneum associated with mittelschmerz was confirmed. A presacral cyst was distinguished from a pelvic mass. At the request of some of his surgical colleagues, the operator has had the opportunity to turn the laparoscope upwards to explore the upper

abdomen, particularly in the search for confirmation of liver disease and to facilitate directed liver biopsies. In this fashion, it was possible to distinguish between cirrhosis, congestive heart failure, and metastatic disease.

Procedure[1,2,10,11]

The preoperative preparation is the same as for most abdominal procedures except that the patient is given paregoric 4 ml at bedtime (to quiet and deflate the bowel). Induction of anesthesia[8,9] is accomplished with sodium thiopental (Pentothal®) followed by intubation and gas by mask. Prior to the anesthetic, the patient is positioned so that the buttocks rest over the upper edge of the hexagonal cutout at the center of the table. A foot extension is added to the end of the table to accommodate the patient's legs, which are placed on the pad, so positioned that the space in the center of the table is empty. The patient's legs are placed in lithotomy position and a catheter is left indwelling during the course of the procedure and attached to continuous drainage. A bimanual examination is performed under anesthesia. For purposes of manipulation, either the Semm cannula or the Kahn cannula is affixed to the cervix, the former by suction, the latter in conjunction with a tenaculum. (These instruments are utilized for manipulating the position of the uterus during the procedure.) The legs are then placed down upon the pad once again with an intervening well-lubricated ground plate attached to the Bovie unit. A strap is placed across the patient's thighs and padded shoulder braces are put into place. If the patient is positioned correctly, the cannula falls cleanly into the hexagonal space beneath the buttocks. The patient is then prepped and draped as for an abdominal procedure.

TABLE 4—*Concurrent surgery (196 cases)*

Dilatation and Curettage	118
Suction Curettage	6
Laparotomy	38
Myomectomy	2
Chronic Pelvic Inflammatory Disease with Lysis	7
Ovarian Resection	7
Uterine Suspension	3
Salpingo–oophorectomy	4
Ectopic Pregnancy	4
Tubal Ligation for Failed Laparoscopy	2
Moskowitz Obliteration	1
Endometriosis	4
Tubal Plastic Repair	2
Hysterectomy	2
Via Laparoscopy	7
Cautery of Endometriosis	1
Aspiration of Ovarian Cyst	4
Liver Biopsy	2

A stab wound incision is made beneath the umbilicus and a Verres needle is inserted. Carbon dioxide (CO_2) is then directed through the Verres needle from the insufflating device. (Our equipment contains 5 liters of CO_2 and will measure the rate of flow, the amount of CO_2 dispensed, and will indicate the pressure at the end of the delivery system in the peritoneal cavity.) The initial intraperitoneal pressure is approximately 12–16 mm Hg. It will often rise 4–10 mm during the course of the insufflation, but we have learned to become concerned should the pressure rise much above 20 mm Hg. The rate of flow is moderate, taking approximately 4 minutes to instill the necessary 3½–4 liters of CO_2. The needle is then removed and the incision broadened just enough to accept the 10 mm trocar and sleeve. This is thrust into the peritoneal cavity at a 45-degree angle. A specific "pop" usually can be felt as the trocar penetrates the peritoneum. The trocar is removed and a rush of CO_2 outwards indicates the location of the end of the sleeve within the peritoneal cavity. The laparoscope is attached to its light source (150 watts for usual viewing, 1000 watts for photography), and inserted into the sleeve. The CO_2 is reattached to the sidearm of the sleeve and another liter of CO_2 is inserted to compensate for loss during manipulation.

A second 6-mm incision is made to the left of the midline in the lower abdomen. The fiberglass sleeve and trocar are thrust into the peritoneal cavity under observation through the laparoscope. The trocar is then replaced by the Eder biopsy tong, which is not attached to the cautery unit as yet.

The patient is then placed in steep Trendelenberg position. Using the biopsy tong, small bowel and sigmoid are moved away from the uterus. At the same time a nurse manipulates the cervix so as to bring the uterus upwards and forwards, thereby exposing the Fallopian tubes. At this point, the entire pelvis can be viewed and a number of procedures can be performed via the lower incision, such as tubal cautery, biopsy of the ovary, incision of adhesions, evacuation of ovarian cysts, evacuation of ascites, and cauterization of bleeding points or endometrial implants.

Concurrent Surgery[5]

Exclusive of the 304 tubal cauterization procedures, it was not unusual to find surgery performed concurrently with the laparoscopies. Of the remaining 196 cases (Table 4), a dilatation and curettage was performed concurrently in 118. The indications were related to the diagnosis of abnormal uterine bleeding, in association with infertility problems, for the removal of intrauterine devices, and related to a number of other indications. Laparotomy was per-

formed in 37 cases (approximately 20%). In many of the early cases, the laparoscopy was done for diagnostic and experience purposes, although the laparotomy had already been scheduled. The definitive procedure was then performed. Four laparotomies were performed because of failed laparoscopies or because of bleeding secondary to the laparoscopies.

On 14 occasions ovarian biopsy was performed, generally to establish diagnoses of sclerocystic ovaries or streak ovaries. On four occasions it was possible to determine the benign nature of large follicular cysts; these were aspirated and collapsed.

A number of other procedures were performed through the laparoscope. These included lysis of adhesions, cautery of early endometriosis, and biopsy of the liver.

Conclusion

Our experience with the first 500 cases of laparoscopy at the Mount Sinai Medical Center, Milwaukee, Wisconsin, has been described. The vast majority of cases were performed in women during the reproductive years. The indications at the beginning were primarily diagnostic, usually in association with endocrine and infertility problems. This has been rapidly superseded by utilizing the procedure for the purpose of tubal sterilization. The indications and findings are varied, and consist of excluding or observing pathology related to the ovaries, tubes, and uterus. Concurrent surgery is often performed, much of it through the laparoscope itself, some of it in association with related procedures. Complications have been few and easily managed. At our institution, the procedure has established itself as a most valuable diagnostic and therapeutic tool.

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Preventing Rheumatic Fever and Rheumatic Heart Disease

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American Family Physician, March 1973

Cooperation between physicians, particularly primary physicians, and other health personnel is needed to conquer rheumatic fever and rheumatic heart disease (RHD). Unlike all other major cardiovascular diseases, RHD can be completely eradicated since effective preventive measures for its precursor, rheumatic fever, are known. However, despite our knowledge of these preventive measures, the incidence of rheumatic fever and RHD have not diminished appreciably in the United States, with 100,000 new cases occurring annually and only an approximate 30 percent reduction in the last 30 to 40 years.

Primary physicians should practice preventive techniques for rheumatic fever and RHD diligently and treat any streptococcal infection seriously, since it may be a prelude to rheumatic fever. Primary prevention of rheumatic fever and RHD is essentially prompt diagnosis and adequate treatment of the group A beta-hemolytic streptococcal pharyngitis which causes rheumatic fever. The only available method for accurately confirming a clinical diagnosis of a streptococcal infection is the throat culture, and is thus essential for all patients with acute pharyngitis, regardless of symptoms or signs.

When treatment is indicated, antistreptococcal therapy must continue for a full ten days to be effective. Intramuscular injection of benzathine penicillin G is recommended, or erythromycin if the patient is penicillin-sensitive; usage of tetracyclines or sulfonamides is not effective in the treatment of many streptococcal strains.

Secondary prevention of RHD involves prevention of repeated attacks and further heart involvement, with continued prophylaxis the safest approach, with few exceptions. As in primary prevention, intramuscular injection of benzathine penicillin G is the most reliable treatment. The Jones criteria, available from local heart associations and internists and cardiologists, can aid the primary physician in doubtful diagnoses, as well as with the problem of the advisability of physical activity. The Inter-Society Commission on Heart Disease Resources (ICHD) report, "Prevention of Rheumatic Fever and Rheumatic Heart Disease," published in *Circulation* in 1970, in detailing guidelines for utilizing primary and secondary prevention to limit RHD in the population as a whole, recommends regional committees and registries to correlate data and to assist physicians, paramedical and allied health agencies, schools, and public health agencies in community-wide prevention programs. □

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Edited by Gastone G. Celesia, MD, Secretary–Treasurer

Psychiatric Disturbances in Parkinson's Disease

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The psychiatric disturbances of 153 patients suffering from Parkinson's disease were studied. Sixty-one patients (40%) had impairment of cognitive functions. The severity of the cognitive impairment was mild in 24 patients (16%), moderate in 26 (17%) and severe in 11 (7%). The frequency and severity of the cognitive impairment correlated closely with the duration and severity of Parkinson's disease. The cognitive deficit is most likely related to cerebral atrophy.

Fifty-seven, or 37% of the patients, had depressive symptoms before receiving levodopa therapy. The prevalence of depression in patients receiving dopa dropped to 24%, a small but statistically significant difference.

Acute psychotic disorders occurred in 20 (13%) patients. They were usually related to drugs and in 75% of the cases occurred in patients with impaired cognitive functions. □

Some Clinical Characteristics of Patients with Clinical Seizures and Normal EEGs

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Ten patients with clinically documented generalized motor seizures, normal neurologic examinations, and normal awake and sleep electroencephalograms (Group I) were compared with four other groups of patients with seizure disorders.

Patients in Group II had focal paroxysmal EEG abnormalities; those in Group III had generalized paroxysmal EEG abnormalities; those in Group IV had generalized non-paroxysmal EEG abnormalities; and those in Group V had focal non-paroxysmal EEG abnormalities.

Paroxysmal abnormalities are defined as spikes, spike-and-wave complexes, or polyspikes. Non-paroxysmal abnormalities are defined as delta waves occurring in the absence of sleep.

All patients were randomly selected, on the basis of initial EEG results from the data retrieval system of the Wisconsin Epilepsy Center. This system contains EEG and clinical data on more than 2,000 patients, and about 50% of the EEGs contain paroxysmal abnormalities. Minimum follow-up for each patient in this study was one year.

Age, sex, age of onset of seizures, duration of follow-up, family history of seizures, and neurologic findings were of little value in predicting each patient's ultimate functional (e.g. social, economic, educational) status. Associated diseases, such as mental retardation, encephalitis, hydrocephalus, and cardiovascular diseases, were more common in patients with focal *or* generalized EEG abnormalities.

Patients in Group I had a significantly better functional prognosis when compared with patients in Groups IV and V combined ($P \leq 0.001$). This was a pilot study utilizing small numbers of patients and no other inter-group comparisons were statistically significant. □

Congenital Universal Muscle Hypoplasia

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A case of a 23-year-old, white male with diffuse muscle hypoplasia is presented and the similarity of this patient to the cases of benign congenital hypotonia of Walton and the congenital universal muscle hypoplasia of Krabbe is discussed.

In his original article Walton reviewed cases diagnosed years earlier as amyotonia congenita and re-examined them. He fit many of these patients into his classification of benign congenital hypotonia. In this classification he included the case of Krabbe. He concluded that benign congenital hypotonia represented a condition of non-progressive hypotonia which often improved during post natal development. Most of his patients had complete recovery but those with incomplete recovery showed only diffusely thin muscles and mild proximal weakness with preservation of deep tendon reflexes upon reexamination in their teens.

The EMG and muscle biopsy were normal. Our patient had small thin muscles and slight hypotonia but had strength proportional to muscle bulk. The deep tendon reflexes were normal as well as the EMG and muscle biopsy. The only abnormality was an elevation of urinary creatine. □

☐ *A plea is made for physicians to join with national organizations such as the American Cancer Society in urging the practice of preventive medical measures. But more imperatively, physicians are urged to become more active in doing pelvic examinations as part of their routine office evaluation of patients.*

Screening Program for Squamous Cell Carcinoma of Cervix

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SQUAMOUS CELL CARCINOMA of the cervix remains a leading malignancy of women. In spite of efforts made toward early diagnosis by the Papanicolaou smear, the disease in many patients is not detected until they have developed an invasive lesion. The importance of this malignancy becomes apparent when the statistics from the Division of Health, Bureau of Health Statistics—State Department of Health and Social Services, are reviewed. In 1968 the Division recorded 122 deaths from malignant neoplasms of the cervix.[1] In Wisconsin, squamous cell carcinoma of the cervix is ranked second in numerical importance among female cancers and was responsible for 13% of all female cancer. In the age group 25–34 years it accounted for 52.8% of all female cancer. Approximately 50% of these lesions were *in situ*.[2]

This study was begun in an attempt to determine why squamous cell carcinoma of the cervix is often not detected before it becomes invasive. To do this, the records of 100 patients who resided in Wisconsin and had been treated for cervical carcinoma of Stage II (51 patients) and Stage III (49 patients) were reviewed. These patients were admitted between 1962 and 1968. The charts were reviewed for age at diagnosis, gravidity, age at menopause, symptoms, method of diagnosis, and number of years since last pelvic examination. To assist in gathering data, letters were sent to the referring physicians asking the method of diagnosis and last recorded pelvic examination and Papanicolaou smear.

Seventy-three of the 100 physicians returned the questionnaire. These 73 included 49 general practitioners, 18 obstetrician–gynecologists, 4 general surgeons, and 2 internists. In 36 cases the referring physician considered himself the patient's primary physician.

In this small series there was no difference between the age, gravidity, years since menopause or duration of symptoms in patients with Stage II and Stage III lesions.

Table 1 summarizes the symptoms and signs which prompted the patients to seek medical attention. One-half of the patients indicated that they had been symptomatic less than six months. Two patients had had pain and two patients had had vaginal discharge as the only symptom.

The duration of time since the last pelvic examination is indicated in Figure 1. This information on 70 patients was derived from the hospital records and those of the referring physician. Since only 7 of the 70 patients had had a pelvic examination in the year preceding their admission, it is clear that the invasive disease persists in Wisconsin primarily because of inadequacies in our screening and detection programs.

In Table 2 the method of detection used by the 73 responding physicians is indicated. Six patients were admitted to the hospital with hemorrhage, transfused, and the diagnosis made. Five had negative Pap smears. The diagnosis was subsequently made by biopsy. Referring physicians followed up abnormal Papanicolaou smears on 30 patients with biopsies. There were delays in making the diagnosis in eight cases. Two patients had atypical cervical cytology and were not investigated further. Two patients had vaginal discharge but were not examined. One patient with a urinary tract complaint was not examined until a subsequent visit. Three patients had abnormal bleeding and were treated with hormones without examination.

TABLE 1—*Common symptoms*

	Stage II	*Stage III*
Discharge	19	14
Bleeding	40	42
Pain	10	15
Post coital bleeding	12	6
Routine physical exam	3	
Urinary tract symptoms	2	

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Discussion

This study indicates surprisingly that the duration of symptoms was relatively short in the presence of these advanced lesions, and with few exceptions a diagnosis was made promptly. The number of false-negative cytologic smears was high considering the advanced nature of these lesions.

As previously stated, there is a false-negative rate even with advanced lesions which requires that an abnormal appearing cervix must be biopsied regardless of the cytology. The Papanicolaou smear is a screening test, and like screening tests, anything which is not normal needs to be investigated further. When one receives a report of an abnormal Papanicolaou smear (atypical, suspicious, or positive) or the cervix appears abnormal, the patient should be examined by colposcopy if available so that directed biopsies can be performed. Most believe that with cervical cytologic examination and directed biopsy the accuracy of diagnosis in the detection of cervical abnormalities is maximum. If colposcopy is not readily available, then multiple cervical biopsies should be performed using Lugol's solution, a procedure which should render an accurate diagnosis in excess of 90% of the time.[3] Well done biopsy has the advantages of: (a) an office procedure, (b) detecting the presence of invasion in early cancer in 90% of the cases, (c) less expense for the patient, and (d) less morbidity than a conization of the cervix.[4]

Adequate biopsy with or without colposcopy will almost always demonstrate invasion if present, but if there is uncertainty, then a conization of the cervix is indicated. Of course the accuracy of biopsy is dependent upon an adequate number of biopsies and proper selection of nonstaining areas at or near the squamo-columnar junction. Gynecologic oncologists believe cervical conization has a definite place in diagnosis but should be avoided in invasive lesions if possible. Conization may distort the anatomy of the cervix and upper vagina which in turn makes satisfactory intracavitary radiation more difficult.

TABLE 2—*Method of detection*

Positive Papanicolaou smear	53
D&C and cervical biopsy or cone	17
Gross diagnosis	3
Total	73

(Operative procedure performed on 25 of the above)

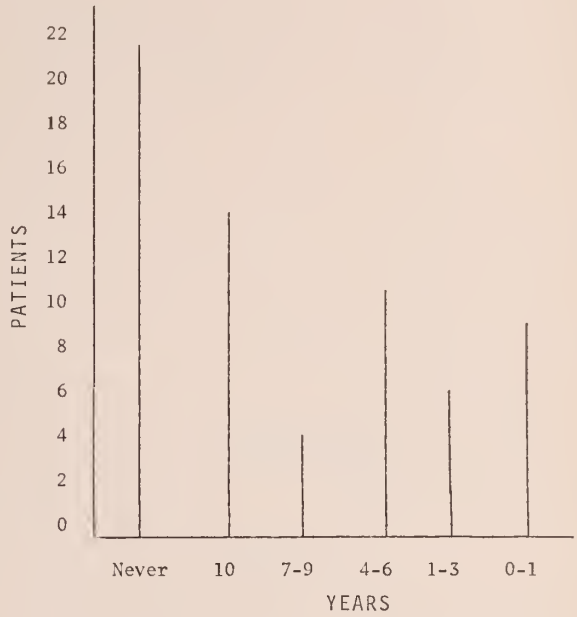

Figure 1—Years since last pelvic examination in 70 patients.

Also conization cuts through the malignancy as well as producing an inflammatory reaction.

Invasive squamous cell carcinoma of the cervix continues to be a frequently seen neoplasm. Most obvious from this study is the fact that the majority of women with these advanced lesions had not had a pelvic examination for years prior to the diagnosis. Physicians should join with national organizations such as the American Cancer Society in urging the practice of preventive medical measures, but more than this, it is imperative, that physicians be more active in doing pelvic examinations as part of their routine office evaluation of patients. They should encourage employers to require a Papanicolaou smear and pelvic examination as a prerequisite to employment and as an integral part of annual health examinations.

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Primary Prevention of Hypertension

Inter-Society Commission for Heart Disease Resources

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HYPERTENSION AND/OR hypertensive heart disease constitute one of the most critical health problems of our time. The 1962 National Health Examination Survey, using among other criteria the presence of systolic blood pressure 160 mm Hg or over and/or diastolic blood pressure of 95 mm Hg or over, estimated that 20% of the adult population of the United States suffer from hypertension. Thus hypertension is second to coronary heart disease in cardiac disease incidence. Unlike coronary heart disease, however, there is only minimal understanding of the pathogenesis of essential hypertension.

Although no specific primary preventive measures can be applied to the disease at present, epidemiologic studies and clinical observations have identified clues to the essential hypertension-prone individual and uncovered possibly related causative trends. If hypertension should develop, prompt and effective control should be initiated. Secondary hypertension, a disturbance of considerably less frequent occurrence for which several etiologic factors are known, offers more hope for amelioration or correction.

Prepared by Doctor Hellmuth from the report of the Hypertension Study Group. Chairman: J. Edwin Wood, MD; Members: J. Gordon Barrow, MD; Edward D. Freis, MD; Ray W. Gifford, MD; Walter M. Kirkendall, MD; Richard Lee, MD; Helen Williamson, RN; Consultant: Herbert Abrams, MD; Irving S. Wright, MD, National Chairman; Donald T. Frederickson, MD, Project Director.

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Essential Hypertension Proneness

The Hypertension Study Group of the Inter-Society Commission for Heart Disease Resources concluded in its report that sustained essential hypertension will occur more frequently: (1) when blood pressure is borderline or high for a given age, (2) when there is fluctuating elevation of blood pressure, (3) when the individual is overweight, (4) when family groups have a history of hypertension, (5) when tachycardia is present, (6) when hypertension and fleeting edema exist during pregnancy, (7) in women, particularly after menopause, more than in men, and (8) in blacks with greater frequency and severity than in whites.

The physician should be alert to these predisposing factors to essential hypertension when examining normotensive individuals. The Study Group recommends the following outline:

A. History
   1. *General*
      Sex, race, weight
   2. *Family History*
      Coronary artery disease or strokes, especially in early age groups (under 50 years of age), and high blood pressure in one or more parents and/or siblings.
   3. *Medical history in the subject*
      Tachycardia, transient blood pressure elevation, toxemia of pregnancy, blood pressure in the upper range of normal for a given age.

B. Physical examination
   Age, elevated pulse rate, borderline high blood pressure in relation to age, obesity, transient blood pressure elevation.

Tentative Preventive Measures for Essential Hypertension

Studies of essential hypertension, although inconclusive, suggest several methods of control and partial amelioration. Although it has not been fully established in human research studies, excessive salt intake appears to elevate blood pressure; thus sodium chloride ingestion should be limited.

Clinical observations and epidemiologic studies revealed some individuals under psychological stress to have labile and fluctuant blood pressures in an elevated range. Such disturbances may contribute to the development of sustained hypertension. Elevated body weight may also contribute to high blood pressure; therefore, reduction diets should be prescribed for the obese individual.

Since hypertension predisposes as well as hastens the onset and severity of atherosclerosis and its sequelae, primary prevention measures should be initiated for hypertension-prone individuals who are also at high risk of atherosclerosis (e.g., increased blood lipids and cigarette smoking); however, not all individuals at high risk of atherosclerosis are predisposed to hypertension, and reduction of risk factors will not necessarily retard the development of hypertension.

Secondary Hypertension Causative Factors

Although secondary hypertension is far less frequent and severe than essential hypertension, its importance should not be minimized. Several causes for secondary hypertension have been identified and some cases can be alleviated or corrected (e.g., coarctation of the aorta and renovascular hypertension may be amenable with corrective surgery).

The Hypertension Study Group recommends a history and physical examination for those, particularly the young, who at present have or are susceptible to secondary hypertension.

A. History
   1. *Family History*
      Pheochromocytoma, polycystic kidneys, or other renal disease.
   2. *Medical history and system review*
      Polycythemia vera, prior urinary tract diseases such as calculi, renal infarction, nephritis, pyelonephritis, proteinuria, disparity of kidney size, steroid therapy, hyperthyroidism.

B. Physical examination
   Tachycardia, excess sweating, abdominal masses, abdominal striae, inappropriate acne, dorsal thoracic bruits, lower blood pressure in the leg than in the upper extremities, and orthostatic hypotension.

C. Laboratory studies
   Appropriate diagnostic procedures as indicated in suspects identified above.

Preventive Measures for Secondary Hypertension

As secondary hypertension is most commonly caused by kidney diseases, it can be prevented through control of those diseases. For example, renal vascular stenosis or related tumors and lesions of the adrenal gland can be corrected surgically. More common kidney infections such as genito-urinary tract lesions and bilateral renal parenchymal diseases should be treated early with antibiotics and/or surgery to offset complications.

Although the association between acute and chronic glomerulonephritis has not been conclusively proved, glomerulonephritis should be prevented through control and treatment of group A beta-hemolytic streptococcal infections. When causative involvements are prevented, identified or treated,

secondary hypertension is also prevented, corrected or controlled; thus secondary prevention, prompt diagnosis and adequate treatment of underlying disease processes, becomes specific primary prevention in this form of hypertension.

Conclusion

The unknown etiology of essential hypertension precludes specific primary prevention at this time, but its magnitude demands further research to locate specific causes. In the meantime every attempt should be made to identify hypertension-prone individuals and to apply indicated preventive measures. For known hypertensives, early diagnosis and adequate management are essential. □

Trichomonas and Yeast Vaginitis in Institutionalized Adolescent Girls

HANIA W. RIS, MD and RUTH W. DODGE, MS, Madison, Wis: *Amer J Dis Child* 125:206–209 (Feb) 1973.

A previous study in a closed population in a state school for girls has shown a gonorrheal prevalence of 11.8% in the years 1965 to 1968, inclusive. Reported here are the results of a concurrent study of *Trichomonas vaginalis* and yeast infections which has been extended to 1971. The majority of the students give a history of past sexual intercourse and 10% to 15% are pregnant at the time of admission.

Although *Neisseria gonorrhoeae* infections in the mature woman primarily involve the cervix, infections with *T vaginalis* and yeast primarily involve the vagina. In instances in which the students are infected with *N gonorrhoeae* alone, the complaint of vaginal discharge is rare. On the other hand, when the infection is caused by *T vaginalis* the patient will frequently but not always complain about vaginal discharge. The discharge associated with *T vaginalis* infection is white, or white-tinged with gray or yellow, frothy, bubbly, mucopurulent, and has an acrid odor. Occasionally multiple, punctate, red erosions are seen on the vaginal mucosa. There is a wide range of clinical manifestations from almost asymptomatic to profuse, malodorous discharge associated with severe pruritus.

Concomitant infection of the urethra in the woman may present a burning sensation on urination and simulate a bacterial urinary tract infection.

The typical discharge of the *Candida* infection is white, curded, and flaky, and sometimes adheres in patches like a plaque to the vaginal mucosa. According to Gardner less than 50% of women with symptoms related to yeast infections show evidence of adhering patches. The infection may cause marked pruritus of the vulva and vagina. In severe cases there may be burning on voiding as a result of urine coming in contact with the infected vulva, which often appears fiery red.

The prevalence of *T vaginalis* infection in our population is high (35.2%). Gallai and Sylvestre cite a reported incidence range from 3.4% to 15.4% in healthy women. Gray and Barnes report an incidence of 10% in private practice of gynecology, 30% in clinic practice, and 85% in the inmates of a woman's prison. Dunkelberg et al found an incidence of 38% in a female population attending a venereal disease clinic.

There is no consensus as to the mode of *Trichomonas* infection. At the present time, most investigators believe that the infection is transmitted by sexual intercourse.

The diagnostic method of the gram-stained smear used in our study was utilized since the vaginal secretion did not have to be screened immediately as is required in fresh, wet-mount preparations. Several investigators reported that smears stained with various dyes yield as high a rate of positive specimens of *T vaginalis* as do wet-mount preparations.

Systemic metronidazole (2-methyl-5-nitroimidazole-1-ethanol)—Flagyl® in the treatment of *T vaginalis* has proven to be highly effective and is presently the drug of choice. The reported cure rates have varied from 88% to 100%; relapse is thought to be often due to reinfection by the sexual partner. The discovery of yeast in either the smear or culture, or both, in our patients does not constitute an indication for treatment unless symptoms are present. Treatment consists of nystatin vaginal tablets (100,000 units) inserted in the vagina daily for 14 days.

Although the prevalence of *N gonorrhoeae* infection in our population is high (11.8%), the prevalence of *T vaginalis* infections was found to be even higher (35.2%). With the increasing use of oral contraceptives in adolescents, an increase of yeast infections can be anticipated. It is recommended that appropriate direct smears should be obtained and screened for *T vaginalis* and yeast in addition to cultures for *N gonorrhoeae* from all girls with a history of vaginal discharge. □

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INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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ethinyl estradiol/50 mcg.

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Typical characteristics of the "balanced" profile

- normal menses
- well-rounded breasts
- clear complexion
- normal figure with normal secondary sex characteristics
- normal cytohormonal pattern

This "center spectrum" pill has had excellent user acceptance for over seven years.

Typical characteristics of the slightly hyperestrogenic profile

- heavy flow
- large breasts, sometimes fibrotic; nipples well pigmented
- very feminine appearance occasionally short
- premenstrual syndrome, fluid retention
- tendency to uterine fibroids
- high pyknotic index

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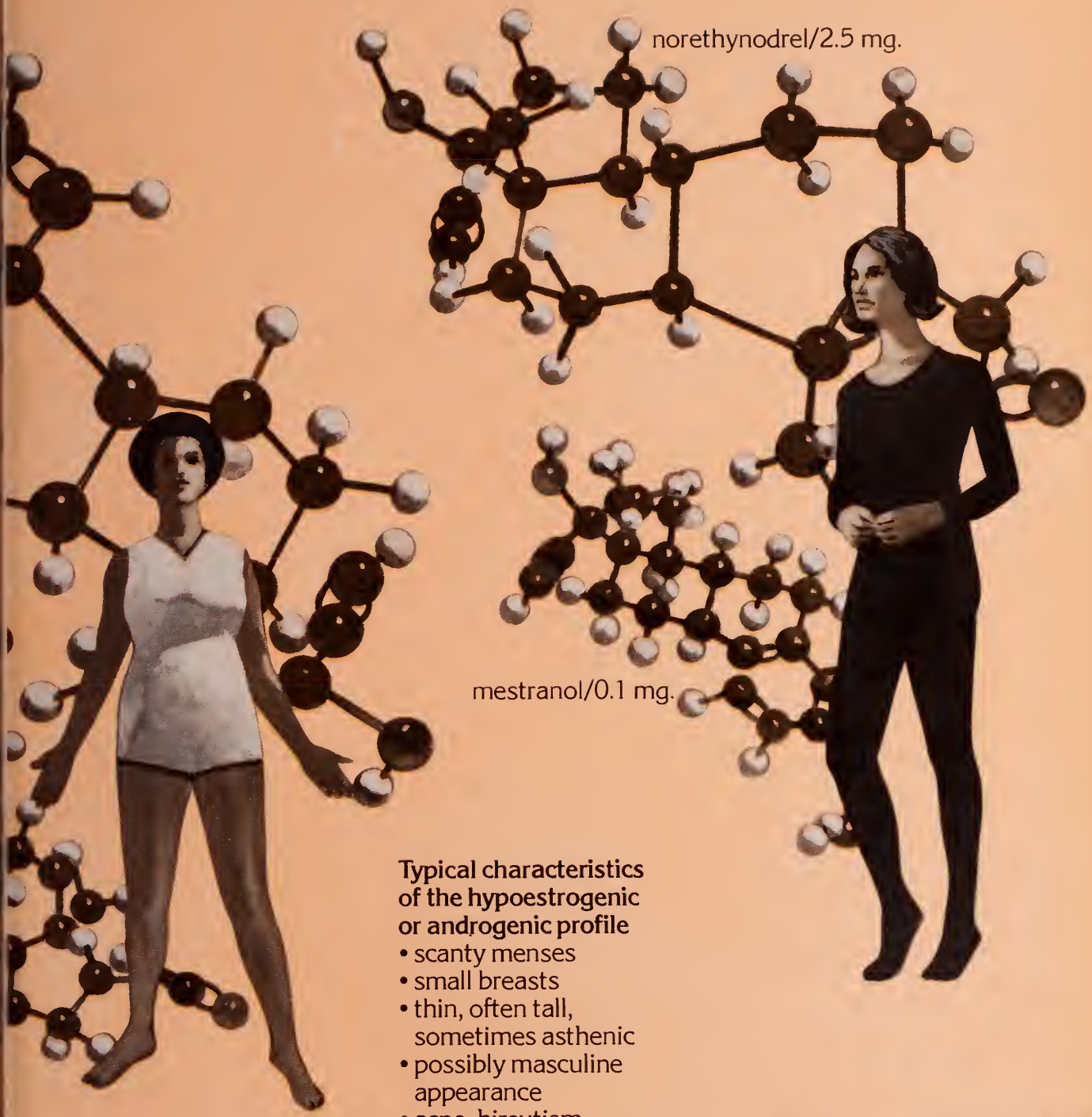
for the majority of women... when centrally balanced activity is preferred

For brief summary of prescribing information, please see next page.



Typical characteristics of the hypoestrogenic or androgenic profile

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- thin, often tall, sometimes asthenic
- possibly masculine appearance
- acne, hirsutism
- low sexual motivation
- thin vaginal lining, tendency to vaginitis and dyspareunia

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Well suited to most women when low estrogenic activity and moderate progestogen dominance are preferred

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Each pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

Enovid-E®

brand of norethynodrel with mestranol

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 6 JUNE 1973

FROM THE PRESIDENT

We Have Not Gotten the Message Across

THE GREAT CHALLENGE facing medicine today is to be effective in leading a winning offensive against the advocates of state-controlled medical care and the welfare state.

The threat of socialism by whatever euphemism you may label it runs not only to the private practice of medicine but also to every facet of American life. None has a greater interest nor a clearer responsibility than the deliverers of medical service.

We are the trustees in Wisconsin to over 4 million who are dependent on us. To these people we are committed in our free enterprise system.

We find a growing segment of our people—not just the young—who, because they do not understand them, feel private medicine and enterprise are evil.

How evil is it to stand for our freedoms? I believe it is noble to resist systems which might deprive us of our right to practice our profession as free men.

How evil is it to spend hours on hospital and community review committees to raise the quality of standards of medical care?

Is it wrong to work with and support the Governor's Task Force in better than 90% of its proposals?

What is wrong with the fact that MD care has been infinitesimal as a factor in cost-of-living raises for 18 months?

Is it wrong to suggest that a Wisconsin Health Corps could help alleviate inadequately cared for medical areas? I believe this idea is sound.

Is it wrong to support experimentation with HMOs; insurance for the unemployed and uninsured; expansion of medical school enrollment; forgiveness loans for worthy students; and support for regional medical programs and area-wide health agencies?

Is it wrong to seek support for a medical disciplinary board, financial support of quality review activities, immunity from suit while doing peer review activities, and reasonable certificate of need legislation for institutions?

To achieve the above objectives, physicians must lead the way by greater involvement in the political and educational processes. Only through our efforts can patients continue to rank us Number 1 in their opinion polls. Only through our efforts can we convince political leaders that change is something you do *with* someone and not *to* someone.

G. J. Derus M.D.

STAT

Leaving No Doubt

If there was any doubt about the politicizing of health care and the importance for the physician to be heard. Governor Patrick Lucey removed it last month. An example of a physician being heard was two of the Governor's speeches given two weeks apart.

In Cleveland on April 27 the Governor told leaders of the UAW, AFL–CIO, and the Teamsters that labor pioneers in health care. In contrast, "as protectors of the status quo, no group in our society has been more active than physicians."

He cited labor for selflessness, commitment, and creativity in such areas as national health insurance, regulation of health providers, and reorganization of health care delivery. He characterized "the solons of organized medicine" as taking "a negative position on proposals to change the financing and organization of health care in this country" while having "a virtual monopoly on services."

The Governor received some feedback on those statements. Among the most expressive was a letter from State Medical Society Vice-speaker Patricia J. Stuff, MD, Bonduel, which ended by calling for an apology "to *all* the doctors of Wisconsin."

Ten days after Dr. Stuff's letter arrived, Governor Lucey spoke to the annual meeting of the Wisconsin Public Health Association (WPHA) in Madison. He again mentioned "the resistance of organized medicine" in connection with his Health Task Force but termed it "not the major obstacle." Now, he said, the major obstacle is public apathy to government's programs.

He went on to quote from two paragraphs of Dr. Stuff's letter as an example of a "dedicated professional." He followed by characterizing the U.S. as "the country with the best trained medical professionals in the world, with the best facilities, and with a high level of professional dedication." He said his aim was to make Wisconsin the model for the country in having "the best possible health care for all."

To do this, he said, he needed WPHA's support—presumably including its physician members.

Counter Conference

Speaking of monopolies . . .

On the same day the AMA held its Midwest Regional Conference on Quackery in Madison a group called the National Health Federation (NHF) came to town with a "Congress on Medical Monopoly." The federation, composed mainly of chiropractors, anti-fluoridationists, and health food enthusiasts, has held such a meeting in conjunction with AMA quackery conferences over the past 10 years.

Speakers included a retired dentist and a Wisconsin attorney attacking fluoridation, a chiropractor lambasting the AMA and government-sponsored studies finding chiropractic unacceptable, and a health food proprietor who took the FDA to task over legislation which would limit the potency and advertising of vitamins sold without a prescription.

The theme of the day was that chiropractors, anti-fluoridationists, and health food supporters are beleaguered because the AMA wants physicians to somehow monopolize the health care field.

The group's major thrust is legislation. The 56 NHF members present dutifully ratified three resolutions in support of chiropractic legislation. One asks for chiropractic's inclusion under Title 19 programs, another calls for chiropractic "in all health insurance contracts," and the third asks for such plums as allowing chiropractors to offer their services to hospitalized patients.

Not Two Standards

Meanwhile, across town . . .

At the noon luncheon during the Midwest Regional Conference on Quackery, physicians and their guests heard a member of the AMA Board of Trustees call for MD standards for chiropractic education and training.

Donald E. Wood, MD, said that if chiropractors are included under Medicare, their standards must be the same as doctors of medicine. He said there should not be "two standards of service —scientific and cultist."

The Indianapolis internist said that medicine's position that chiropractic is totally unqualified as the separate and complete health care service it claims to be has been supported by numerous studies. He cited a number by various federal government agencies, the scientific community, organized labor, and national consumer groups.

His talk highlighted a day of conferences among representatives of 12 state medical societies. Each reported experiences with chiropractic legislation.

Finally, Success?

If at first you don't succeed . . . Success finally came to the Medical College of Wisconsin in its search for a way toward the $33 million it needs for two new buildings.

Word from Washington is that the feds will guarantee a $20 million private loan to the school. They will also subsidize the interest on the loan, amounting to approximately $600,000 per year for 40 years. The College hopes to get the other $13 million in its fund-raising drive.

Governor Lucey has said he will be making some recommendations soon on the state's "continuing financial and public interest concern" in the College. □

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Is It the Best or Worst of Times?

"It was the best of times, it was the worst of times." Are those first words of Dickens' *A Tale of Two Cities* apropos for contemporary American medicine? They certainly fit the outline given by the two physicians who spoke at commencement ceremonies in Wisconsin's two medical schools last month.

The class day speaker at the University of Wisconsin, James Kimmey, MD, used Dickens' words in comparing technological "gee whiz" medicine and the "health care crisis."

The controversial new secretary of the Governor's Health Policy Council said the ball is now in the court of organized medicine to prove that there is no such crisis. However, he said he did not believe such proof would ever come. Therefore, data on cost, availability, and accessibility of health care accepted by "the political structure of the country . . . as evidence of a problem of crisis proportions . . . must be met by political action," he said.

Less directly, the speaker at Medical College of Wisconsin commencement ceremonies said similar things. Five months after quitting as the United States' assistant secretary for health, Merlin K. DuVal, MD, cited health care problems that are "approaching the flash point." He said too high infant mortality rates, the shortage and maldistribution of physicians and inflated health care costs are creating pressure "for the federal government to take an increasingly large role in our nation's health care delivery system."

How big that role is, both speakers concluded, will depend a great deal on practicing physicians. Dr. DuVal, now vice president for health affairs at Arizona College of Medicine, quoted singer-poet Bob Dylan, "If you are not busy being born, you are busy dying," as a description of how physicians should approach the changing future.

Dr. Kimmey said "American physicians are often characterized as the most individualistic class of professionals left in our society; yet too often they appear to line up and follow the dictates of their professional organization without applying independent judgment to the interpretations presented."

Perhaps the 210 young physicians who graduated from Wisconsin's two medical schools would also do well to remember the way Dickens ended that famous first sentence from *Tale of Two Cities:* "in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only." □

TOP PHOTO: Dr. DuVal at Medical College

BOTTOM PHOTO: Dr. Kimmey at UW Class Day

More New Physicians

Wisconsin medical schools produced 15 more new physicians than they did last year. Class size at the University of Wisconsin Medical School was up 13 and the Medical College of Wisconsin had two more graduates than in 1972.

Wisconsin legislators will be happy to know that the number of new physicians staying in the state went up as well. About one-quarter of the 210 graduates will now go into Wisconsin-based internships or residencies. This year's number, 51, compares with 43 last year. That was about one-fifth of last year's 195 Wisconsin medical graduates.

The University of Wisconsin Medical School reports that 28 of its 107 graduates will stay here, compared with 22 last year. The Medical College of Wisconsin reports that 23 of its 103 graduates will remain in Wisconsin, compared to 21 last year.

Again at both schools the Midwest was the most popular region of the country for continued physician education. The West drew the second largest number of Wisconsin graduates. After Wisconsin, California was the most popular state, drawing 21 graduates of each school. □

Now, the Health Council

Tired of hearing about the Governor's Health Task Force? Just in time is the Governor's Health Policy Council.

Where the Task Force only proposed, it is the role of the Council to dispose. First on its agenda are the 26 recommendations the Task Force suggested be implemented by the Council.

After an initial organizational meeting, the Council's 64 members (including 10 physicians) ranked the 26 items in order of priority. Interestingly enough, on the bottom of the list was education of citizens about chiropractic's hazards and lack of scientific validity and opposition to chiropractic legislation.

Highest priority was given to the creation of a research and development program in Wisconsin. This would be designed to find and test solutions to Wisconsin's most important health delivery problems—a sort of "think tank."

Second was a tie between evaluation of all public health care proposals and action on policy guidelines for providing mental health, alcoholism, drug abuse and developmentally disabled services.

Other items (in order of priority) include: health manpower recommendations; convening a joint practice committee of physicians, dentists and nurses; participation in the federal–state–local health statistics system;

A limited institutional licensure demonstration project; lobbying for changes in Wisconsin's involuntary commitment law; health services for the elderly; review of care of non-acute mental patients in county hospitals;

Establishment of a permanent developmental disabilities committee; evaluation of continuing education programs for health workers; mental health services for children and adolescents; licensing and accrediting of facilities for the treatment of drug abuse;

Planning for nursing and nursing education; research and demonstration projects concerning nursing; statewide implementation of the area health education system concept; study of present legislation controlling the use and possession of illegal drugs;

Establishment of a state health education policy committee; and review and development of new standards for non-psychiatric medical and nursing care in Wisconsin county mental hospitals.

The Council is headed by Ben Lawton, MD, Marshfield. Its executive director is James Kimmey, MD, Madison. Other physician Council members are: MDs Robert R. Baumann, Monroe; Marc F. Hansen, Madison; John S. Hirschboeck, Milwaukee; Gerald A. Kerrigan, Milwaukee; William R. Merchant, Madison; John U. Peters, Fond du Lac; John Ridley, Milwaukee; Hania W. Ris, Madison; and Kenneth Viste, Jr., Oshkosh. □

What Is a PSRO?

What is a PSRO? Even the administrators in Washington don't seem sure at this point. Technically, however, by next month government has the power to say whether any given medical group is a PSRO. Just how much will be done next month seems doubtful at this point, since the program is not yet funded.

For any physician who may have been living in a cave over the winter, PSRO is the acronym for Professional Standards Review Organization. Since Sen. Wallace F. Bennett (R-Utah) successfully made this peer review wrinkle a part of last year's Social Security Amendments, physician groups across the country have been scurrying to qualify. It has been most difficult, however, to determine in which direction to scurry.

Another chapter in the PSRO saga unfolded last month at a Washington meeting of some 39 state physician groups. Heralding their May 23 visit was a letter from Sen. Bennett to his Congressional colleagues. He said the AMA called the meeting to set up PSROs at the state level and take the program away from local doctors.

It appears that most Congressmen took this with a grain of salt. Most of the state delegations, including Wisconsin's, reported cordial receptions from their Congressmen.

Representatives attended from the State Medical Society and Wisconsin Health Care Review, Inc. (WHCRI), the multi-disciplinary review organization formed in 1971 by the state medical, dental, and hospital associations. They were WHCRI president Paul B. Mason, MD, Sheboygan, State Medical Society president Gerald J. Derus, MD, Madison, and WHCRI executive director Donald J. McIntyre.

The most confusing part of the meeting was the most important one. This was a conference with the newly appointed PSRO director, William Bauer, MD, and the man who seems to be calling many of the PSRO shots, Henry Simmons, MD, Deputy Assistant Secretary of Health.

Some of their more intriguing answers included:

- A statewide organization including over 3,000 physicians might *not* be a PSRO . . . *but* an organization of 7,000 Chicago physicians could reasonably be a PSRO.
- Statewide PSROs may be limited to states with small populations . . . *but* an organization in a large state with several reviewing districts could qualify as an overall administrative unit. (This seems to give a green light to WHCRI.)
- No PSROs will be named before mid-November . . . *but* some PSRO areas will be designated soon.
- It will take another three years to get PSRO regulations drafted and approved . . . *but* interim "guidelines" will be used pending final regulations.
- HEW will control multiple local review structures to "protect" the voice of the local physician who is not a member of organized medicine.

The focus of the Washington conference was whether states will have the option of establishing single "umbrella" PSRO organizations. The State Medical Society's position is strongly in favor of WHCRI as Wisconsin's

A Paradox

"Fact 1: Children tend to become adults. Fact 2: Children who become adults tend to raise families. Fact 3: Sick children tend to become sick adults. Fact 4: Sick children who become sick adults also tend to raise families. Fact 5: Sick adults who raise families tend to have A LOT of problems."

These are "medical facts of life" outlined in a flyer being sent to some 2,000 Dane County families. All receive Aid to Families with Dependent Children (AFDC).

The 7,000 children in these families are eligible for a state screening program, the flyer says. Interested parents return a form, checking a box for "a FREE physical examination to help maintain good health and detect any health problems in their early stages."

According to the coordinator of the program, Richard W. Biek, MD, of the state's Division of Health, this will include checks on height, weight, dental problems, anemia, hearing, vision, lead poisoning, TB, immunizations, diabetes, health history, and head circumference.

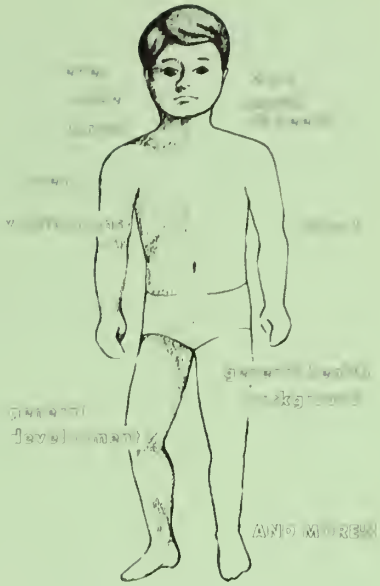
The project is the start of programs to comply with national requirements for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Medicaid recipients.

The law calls for the program to be in effect by July 1, 1973. This is when the Dane County pilot project is expected to start. The goal is to cover the state within the next year.

Although the American Academy of Pediatrics supports EPSDT, it points out in its journal that the program creates a "paradox."

Pediatrics, the Academy's monthly scientific journal, says "the legislation requires that a large segment of the child and youth population, who in the past have received limited medical care, will now receive increased health services. However, the legislation does not offer solutions to the problems of providing these services."

The flyer to Dane County AFDC families says the screening "is a good *supplement*" to the services of the family physician, if there is one. "If you don't have a family doctor *who sees your children regularly* this program is absolutely necessary," the flyer says.



DRAWING FROM EPSDT FLYER
"A free physical examination."

A news release from the state Division of Health says that "all health problems detected by the screening process will be referred to the child's family physician or dentist for complete diagnosis and any required treatment." However, it doesn't say what will happen if the family has no physician or dentist. □

PSRO . . .

single statewide PSRO. The Secretary of HEW is being encouraged to designate multiple state areas as PSROs. The outcome is still not clear.

The 39 groups at the meeting were about equally divided between state medical society representatives and review organizations sponsored, established, founded, or otherwise approved by a state medical society.

All seek statewide PSRO designations. All see multiple PSRO organizations within a state as having the potential to fragment medicine, duplicate administration, and set one review organization against another.

It appears that deciding what a PSRO *is* may be at least as important as deciding what a PSRO *does*. □

Still Growing and Popular

One of medicine's most popular and successful programs is the summer freshman externship. Every year more medical students elect to spend their first summer after beginning medical school working and learning with Wisconsin family physicians.

This summer, the fifth annual program, a total of 76 students from the two Wisconsin medical schools are participating. Last year the number was 70. The only factor that seems to limit the number of students taking part is the number of physicians volunteering to accept them.

The 10-week "live in" experience involves 55 medical students from the University of Wisconsin and 21 from the Medical College of Wisconsin. Each receives an $800 fellowship; $325 comes from the individual physician or hospital to which the student is assigned. The balance has been contributed by WPS–Blue Shield, Surgical Care–Blue Shield, the Wisconsin Rural Rehabilitation Corporation, and American Family Insurance Company. The State Medical Society's Charitable, Educational and Scientific Foundation administers the funds.

The program, organized by the Wisconsin Academy of Family Physicians (WAFP), grew out of an idea from the UW's Family Medicine Club in 1968. WAFP members line up physician participants. Students match potential externs with physicians.

Last year's externship, as evaluated by UW professor Howard Stone, was again found to be a worthwhile experience by both student and physician participants. Professor Stone's report details size of city of externships, students' hometowns, student and physician reactions, and settings in which the students spent time during their summer experience.

For a copy of Professor Stone's report contact him at the University of Wisconsin Center for Health Sciences, 331 N. Randall St., Madison, Wis. 53706. □

MD Shortage Poll Comes Up Short

At times it seems Wisconsin's physician shortage is like the weather: everyone is always talking about it. To stimulate some talking by legislators, the State Medical Society's Special Committee on Shortage of Physicians took a legislative mail poll on the subject. Committee members hoped the questionnaire would help them in trying to do something about the problem.

Response to the questionnaire was not overwhelming. Only 38 of the 132 legislators replied. (Two of the 38 sent letters but did not fill out the questionnaire. Several went beyond the questionnaire to suggest new ideas for exploration. And one polled a number of his constituents for their reactions.)

Those who did reply ranked the family physician as most in demand and sparsely populated areas as most needy. The most confusing question was apparently the one which asked if the legislator had enough ophthalmologists in his area. A third of those returning the questionnaires did not reply to this question.

In comparing the legislators' answers, the most striking contrast came in Milwaukee. A Senate district ranging from the edge of downtown Milwaukee into the suburbs was flatly categorized by its Senator as being adequately served by physicians. This district is bordered by a predominantly black Assembly district. The Assemblyman stated equally flatly that this district is not adequately served. He suggested the situation would be improved by having "one door stop medical and dental service—fully comprehensive services for all including social services."

Only two of the 38 legislators who replied to the questionnaire were totally satisfied with the physician supply in their areas. Both are from relatively affluent urban areas of the state.

One is from a district running north from Milwaukee's suburb of Shorewood into Washington County. The other's district is Madison's residential west side and Shorewood Hills.

Many legislators pointed to the northern part of the state as a physician-short area. The Marshfield Clinic was described as a "last outpost (for the most part)" for medical care by one legislator. He said "there is a need for basic medical care outside a 25-mile area north of Marshfield."

Others specifically mentioned:

- Chippewa County.
- Luck, Frederic, Clintonville, Williams Bay, Bear Creek, Shiocton, Black Creek, New London, Kaukauna, Little Chute, Kimberly, and Tigerton.
- The Kickapoo Valley (The two National Health Service Corps physicians assigned last year have left.)
- Milwaukee's ghetto area and its metropolitan fringes, such as Hartford, Kenosha, Racine, and West Bend.

Legislators were split on whether transportation improvements could ease shortage problems. One said "either free or reduced fares should be instituted for the elderly" to relieve the physician shortage.

Another asked: "Couldn't doctors transport themselves to communities one or two days a week easier than transporting all the patients to central cities for the more routine visits?"

One suggestion was that "every squad car should be an equipped station wagon type so that it can quickly be converted to an ambulance." Another was "24 hour emergency ambulance service from patient's location to the hospital, physician's office or clinic."

Several agreed with the Senator who said "transportation is available if appointments are!"

All but one of the legislators who returned the questionnaire agreed that helpers like physician assistants and former military corpsmen should have an active role in the health delivery system. A few legislators answered only the questions on physician assistants.

Last year the State Medical Society endorsed a bill to certify physicians assistants. It passed only the State Assembly during the last legislative session. Last month another similar bill supported by the Society passed the Assembly with only two dissenting votes.

Here is a sample of legislators' comments on various subjects:

- "I feel the number of doctors should be sufficient to enable them to make house calls routinely and eliminate the present needless hospitalization for minor illness and periods of recuperation."
- "Why shouldn't small town nursing homes, for example, serve as clinic visiting spot in communities without medical service."
- "More Wisconsin-trained MDs might likely remain in Wisconsin if Legislature would mitigate our punitive tax levels and structure. We probably need a miracle to accomplish this under present ideology on spending as a cure." □

GEORGE KRESS

Full Ten

Bringing to a full ten the total of non-medical trustees of the Society's CES Foundation is a leading Green Bay manufacturing executive, George F. Kress. Like the other non-medical trustees, Mr. Kress is a community leader with a number of interests in the medical arena.

Mr. Kress founded Green Bay Packaging, Inc., in 1926, the year after his graduation from the University of Wisconsin. Today the company makes corrugated cartons, plastic and other diversified products, and has plants in Green Bay and Morrilton, Ark.

Mr. Kress heads the boards of both Green Bay Packaging and Arkansas Kraft Corporation. He is also a director of Pioneer Con-

FULL TEN . . .

tainer Corporation, Kellogg Citizens National Bank, and Associated Bank Services.

The George Kress Foundation, which he heads, has given to a number of community projects such as scholarships, the YMCA, the Cancer Society, and the Red Cross.

An avocation to which Mr. Kress has devoted considerable effort is the American Foundation of Religion and Psychiatry. Founded in New York by Dr. Norman Vincent Peale, the organization focuses on combining treatment of mental illness with religious philosophy. Mr. Kress organized the Green Bay branch which provides psychiatric counseling services and trains ministers to do such counseling.

Locally Mr. Kress is also on the boards of the Green Bay Symphony, the United Fund, and St. Norbert College.

The Foundation's other nonmedical trustees are: Mrs. Audrey Baird, Wauwatosa civic leader; George Becker, vice-president of Giddings & Lewis, Fond du Lac; Warren E. Clark, retired special agent with Northwestern Mutual Life Insurance Company, Milwaukee; Donald S. DeWitt, president of the First National Bank of Oconto; The Honorable Carl Flom, Madison; L. O. Graf, retired president of Graf's Beverage, Milwaukee; Mrs. Nancy McDowell, public affairs account executive, McDonald Davis & Associates, Milwaukee; Robert B. Murphy, Madison attorney; and James Morton Smith, PhD, director of the State Historical Society of Wisconsin, Madison. □

FEES

Usual and Reasonable Here and There

Physicians fees vary from one part of the country to another and from one part of Wisconsin to another. Does this variation really reflect differences in cost of living?

For example, in New York City individual surgical fees commonly run double the routine charges in upstate communities. Are such differences justified?

No, according to a resolution adopted in 1971 by the AMA House of Delegates and one adopted in March by Wisconsin's Delegates.

The resolution adopted by the Wisconsin Delegates refers to the AMA resolution. Simultaneously, the Wisconsin Delegates rejected two other resolutions dealing with fees. One supported "a uniform schedule of fees" for all physicians; the other called for "a statewide minimum and advisory fee schedule."

Because the three resolutions have similarities, there has been some confusion about what position was taken. To clarify this, all three resolutions are reprinted here.

The House of Delegates ADOPTED Resolution S, introduced by the Juneau County Medical Society. It states:

WHEREAS, The Bylaws of the State Medical Society of Wisconsin (Chap. VII, Sec. 3) provide A Commission

LEGISLATION

Getting It Together

Legislatively speaking, the State Medical Society is "getting it all together."

At least that was the feeling at a special meeting May 30 for those active in the State Medical Society's CHECKPOINT/CHECKMATE program.

State Medical Society and American Medical Association speakers discussed the issues and political activism with some 100 physicians and their wives (Auxiliary). Most are volunteer contact points with legislators on issues of interest to medicine.

Since the beginning of this year, an almost weekly series of bulletins have gone out on legislation in which the Society is interested. CHECKPOINTS (physicians) and CHECKMATES (physicians' wives) keep their legislators posted on the feelings of medicine. The meeting offered some practical "how to do it" tips. □

LEFT PHOTO: Speakers (left to right) are AMA Field Services Director Richard Layton, Society President G. J. Derus, MD, and Auxiliary Legislative Chairman Mrs. J. D. Kabler. Hidden is AMPAC Associate Director Mrs. Lee Ann Elliott. Other speakers were W. T. Russell, MD, Chairman of the Society's Commission on Public Policy, and G. A. Behnke, MD, WISPAC Chairman.

The Day Comes

Wielding gold shovels, Governor Lucey, UW, and federal officials officially broke ground for the University of Wisconsin Center for Health Sciences last month.

Former Medical School Dean Peter Eichman perhaps summed it up best when he said, "I never thought I'd see this day come."

He was on hand as deputy director of the National Institutes of Health's Bureau of Health Professions, Education, and Manpower Training. That bureau is providing some $14.6 million toward the center's first phase. The total cost for the first phase is $48 million. The entire project, including a 565-bed hospital, will cost $80 million.

Target date for completion is sometime in 1976. The site is adjacent to the Madison Veterans Administration Hospital at the west end of the campus. The new hospital will replace University Hospitals for teaching medical and nursing students. The old hospital is slated to become a basic science teaching facility. □

BREAKING GROUND FOR UW CENTER FOR HEALTH SCIENCES. With VA Center in background, left to right are: UW President Robert Weaver, Governor Patrick Lucey, UW Chancellor H. Edwin Young, NIH's Peter Eichmon, UW Vice-Chancellor Irving Shone, UW Health Sciences Vice-Chancellor Robert Cooke, MD and UW Emeritus Dean William Middleton.

USUAL AND REASONABLE . . .

on Health Information whose duties include "activities to improve the distribution of medical service to the public . . . and all matters of rural health"; and

WHEREAS, The AMA House of Delegates, seeking further support of rural health, has adopted a resolution which stated: *"Resolved,* That since the cost of medical practice is now substantially the same in many rural and urban areas, any inequality in reimbursement for services of rural physicians based on arbitrary differentials between these two areas should be eliminated." (See Medical Staff-in-action, AMA Spring 1972, Vol. 7, No. 1); and

WHEREAS, We know from professional liability court decisions that COMMUNITY wherein a physician practices no longer means a protected, isolated, geographic area, but rather means a COMMUNITY of physicians required to supply equivalent quality of treatment, and thus COMMUNITY wherein a physician practices should have the same meaning in establishing customary, usual and reasonable fees; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin realistically support rural health and seek to improve the distribution of medical services to the public as follows:

1. Eliminate the inequality in reimbursement for services of rural physicians for the reasons given in the AMA House of Delegates Resolution.
2. Recognize that "COMMUNITY" wherein physicians practice is the entire COMMUNITY of physicians practicing in Wisconsin; and apply this concept in establishing customary, usual and reasonable fees.
3. ACT forthwith to gain approval of PHASE III to realize these goals for rural health.

The House of Delegates REJECTED Resolution P, introduced by the Langlade County Medical Society. It states:

WHEREAS, Since the quality of medical care is no longer considered on a geographical basis, therefore monetary remuneration should also be divorced from geographical consideration; and

WHEREAS, As life becomes more cosmopolitan, urban–rural barriers are becoming something of the past; there no longer exists any major differences in the cost of maintaining a medical practice from one part of this state to another and basic cost-of-living factors apply quite evenly to the resident of any city, town, or village; and

WHEREAS, Costs of construction, drugs, supplies, automobiles, and gasoline, are no less in those areas where a relatively low fee schedule exists and rates of taxation at the State and Federal level apply equally to all; and

WHEREAS, Interest rates, mortgage rates, and finance charges are not less in rural low fee areas and sometimes due to less competition are higher as holds true for food prices; and

WHEREAS, The State Medical Society of Wisconsin has always supported the "fee for service" concept; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin support the concept of equal fee for equal service, thereby a uniform schedule of fees for all physician members.

The House of Delegates also REJECTED Resolution Z, introduced by the Green Lake–Waushara County Medical Society. It states:

WHEREAS, It is becoming more apparent that within a short time there will in all likelihood be a standardization of medical fees on a national level, particularly in the advent of government medicine; and

WHEREAS, There is a marked disparity in fee schedules between the urban and rural areas of Wisconsin; and

WHEREAS, Rural practitioners are in need of assistance in the upward adjustment of their fees at this time; therefore be it

Resolved, That the State Medical Society of Wisconsin take immediate action to implement the evolvement of a statewide minimum and advisory fee schedule such as has been done in other states to serve as a guideline only for the physician. □

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SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy

'ATIENTS CAN BE UCCESSFULLY IAINTAINED ON A)RUG CONTAINING 'HYROXINE ALONE.

ıyroxine (T_4) is, as you know, e major circulating hormone 'oduced by the thyroid gland. , is also produced, in smaller nounts, and is active at the ɜllular level. For years it has been working hypothesis among ıdocrinologists that T_4 is ɔnverted by the body to T_3. In)70 this process, called leiodination," was demonstrated / Braverman, Ingbar, and Sterling[2]. , does convert to T_3, though the 'ecise quantities are still being udied.

The conversion has been inically demonstrated during the ıministration of T_4 to athyrotic ıtients. Their thyroid status is ɔrmalized on SYNTHROID alone, ɜt the presence of T_3 in these ıtients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for **Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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COUNCIL MINUTES—State Medical Society of Wisconsin

MILWAUKEE, MARCH 24, 1973

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:15 p.m. on Saturday, March 24, 1973, at the Pfister Hotel in Milwaukee.

All voting members were present: Doctors JJFoley, Olsman, Nordby, Huth, Beilman, Edwards, Smejkal, Mauthe, Dettmann, Rohde, Heinen, Lewis, Manz, Doyle, Egan, LaBissoniere, Williams, Pittelkow, TJFoley, Schmidt, Meyer; Past President Behnke, President Purtell, and Speaker Nereim.

Others present: President-elect Derus, Vice-speaker Hamlin, Treasurer Weston, AMA delegates and alternates Bell, Galasinski, Picard, Dessloch, Twelmeyer, Russell, Kief; Doctors Stuff and Stahmer, reference committee chairmen; Goldstein, Kenosha; Bein, Racine; Peters, Fond du Lac; Biek, Madison.

Staff and consultants: Messrs. Thayer, Koenig, Maroney, McIntyre, Johnson, LaBissoniere, Brodersen, Graham, Bontrager, Doran, Kluwin, Murphy, Sutherland (AMA); Mmes. Anderson and Davenport; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Smejkal–Heinen, carried, minutes of the February 10 meeting were approved.

3. Commission on State Departments

By various motions duly made, seconded and carried, the following were nominated and elected to the Commission on State Departments:

Chairman: Thomas W. Tormey, Jr., MD, Madison

Vice-chairman: Howard G. Bayley, MD, Beaver Dam

Division Chairmen:

- Craig Larson, MD, Milwaukee (Aging)
- D. A. Treffert, MD, Winnebago (Alcoholism & Addiction)
- H. A. Anderson, MD, Madison (Chest Diseases)
- John M. Mills, MD, Green Bay (ENT)
- John J. Suits, MD, Marshfield (Handicapped Children)
- David V. Foley, MD, Milwaukee (Maternal & Child Welfare)
- Henry Veit, MD, Milwaukee (Nervous & Mental Diseases)
- Paul Dudenhoefer, MD, Elm Grove (Rehabilitation)
- J. C. H. Russell, MD, Ft. Atkinson (School Health)
- George Nadeau, MD, Green Bay (Vision)

4. Terms of Members of Council Committees

On motion of Doctors Purtell–Edwards, carried, the Council approved the recommendation of the Chairman and Executive Committee that three-year staggered terms be established for all Council committees where members do not presently have assigned terms, to provide for orderly review of their interest and participation.

5. Report of the Treasurer

The annual report of the Treasurer was accepted by the Council and forwarded to the House of Delegates.

6. Report of the Executive Committee

Doctor Purtell advised that the committee had met Friday night and considered most items on the Council agenda, and indicated he would report committee recommendations as the meeting progressed.

7. Liaison with Nursing

On motion of Doctor Edwards, seconded and carried, the Council approved the recommendation of the Commission on Hospital Relations and Medical Education and the Executive Committee that responsibility for a liaison relationship with nursing, including discussions of joint practice proposals, be removed from the Commission and assigned to a special ad hoc committee.

Named as chairman of such an ad hoc committee was Robert D. Heinen, MD, Oconto Falls, and Douglas D. Klink, MD, Milwaukee, as a member. A Madison physician will be named as a third member of the committee.

8. Committee on Peer Review

A. Reimbursement for peer review services

On motion of Doctor Purtell, seconded and carried, the Council approved the Executive Committee's recommendation that WHCRI and the Society seek to have physicians reimbursed for review work on the basis outlined by the Committee on Peer Review as follows:

(1) That review activities now in progress as well as those in the proposal stage, if implemented, include provisions to pay physicians for case reviews and that these activities be monitored carefully with respect to fiscal as well as other considerations;

(2) That physicians continue for the time being to serve without remuneration for attending committee meetings devoted to policy determinations and development of guidelines, but be reimbursed for travel expenses on a billed basis; further, that physicians be requested to maintain records of time spent in attending committee meetings and to report this to WHCRI, through the committee, together with their recommendations as to remuneration for such services; (the latter is not intended to apply to physicians while serving on hospital medical staff review committees);

(3) That the Council Committee on Peer Review and WHCRI be encouraged to negotiate uniform reimbursement rates on either a state or areawide basis in order to obtain fiscal stability of WHCRI in its formative stage and to obtain a physician response as to adequacy for future budgeting; and

(4) That the committee report back to the Council by or before the 1974 annual session on the results of the foregoing as well as additional considerations that may develop in the interim together with further recommendations to become effective July 1, 1974.

B. Composition of Committee on Peer Review

The Executive Committee also reported agreement with the recommendation that the basic specialties be represented on the Council Committee on Peer Review, and that osteopathy should also be included. There are certain geographic areas not presently represented and recommendations on appointments are being requested from appropriate councilors. Robert F. Douglas, MD, Neenah, was nominated to represent the Fox River Valley and radiology. The Executive Committee also expressed the opinion that the Peer Review Committee should have no more than 25 members.

On motion of Doctor Purtell, seconded and carried, these recommendations were approved by the Council.

9. Report on PSRO Developments

Mr. Thayer reported informationally on recent meetings in Washington and Chicago, and the current status of PSRO guideline development. He believed it important that representation from Wisconsin return to Washington to express the philosophy of WHCRI.

He also reported contacts from HEW in Chicago Region V for suggestions of physicians to assume duties as consultants relating to PSRO-Utilization Review activities in Wisconsin.

10. WRMP Emergency Medical Service Project

The Executive Committee proposed substitute wording to that previously distributed for a Council resolution on this subject which would follow the recent position adopted by the Board of Trustees of the AMA. On motion of Doctor Purtell, seconded and carried, the following resolution was adopted:

> WHEREAS, The State Medical Society and its component county societies are gravely concerned about the discontinuance of the vitally needed Wisconsin Emergency Medical Programs; therefore be it
>
> *Resolved,* That the State Medical Society of Wisconsin actively cooperate with the American Medical Association in an attempt to secure the passage of legislation which will continue Regional Medical Programs' educational, manpower development, and quality evaluation activities.

11. SMS Realty Corporation

Doctor Nordby reported that the board of trustees had authorized the rental of space for WPS activities in a building to be constructed on the former Royal Airport property in Monona to house employees presently located in the Smithback and Loniello buildings, the annex (former church) and the storage facilities on West Lakeside. He said that in July there would be in-depth discussion of all considerations related to future space occupancy of the Society and its divisions, including the question of exercising a purchase option on the new building to be leased for consolidation of certain WPS operations. Only rental was authorized by the trustees, and it was reported also that WPS and others using space at Society headquarters at 330 East Lakeside will enter formal leases with the Realty Corporation.

12. Creation of State Medical Disciplinary Board

The Executive Committee recommended Council approval to introduction of legislation to create the function of a Medical Disciplinary Board in the State of Wisconsin as outlined in material provided the Council, similar to the Board in the State of Washington which had previously been discussed. It was believed that such action should be communicated immediately to various state representatives, without awaiting House of Delegates action, in view of current discussions on such legislative proposals as the Health Services Commission.

On motion of Doctors Heinen–Huth, carried, this recommendation was approved.

13. Councilor District Reports

Councilors reported informationally on activities within their districts. Doctor Heinen suggested that the Society provide leadership training at the state level to aid councilors and officers in communicating with the membership locally and enlisting their involvement in organized medicine.

14. Woman's Auxiliary

Mrs. William C. Janssen summarized Auxiliary activities during her year as president, and received the Council's thanks.

15. Conflict of Interest Compliance Report

Mr. Thayer reported that all those required to file conflict of interest certificates had done so except a newly appointed member of the Commission on Medical Care Plans, Mr. David Vogel, who had been asked to do so only within a matter of days.

16. Consulting Actuary

On motion of Doctors Smejkal–Rohde, carried, the Council accepted the resignation of Mr. Carl A. Tiffany with an expression of appreciation to him for his past services.

Doctor Dessloch indicated that the Commission on Medical Care Plans may wish on special occasions to utilize his services in the future.

17. Report of Finance Committee

Doctor Dettmann reported that the committee had reviewed year-end expenditures and reserves as reflected in the treasurer's report, and also budget performance through February which is too short a period for evaluation.

The committee discussed a recommendation from the Commission on Health Information, as contained in its annual report to the House of Delegates, that the Society assist in financing a series of television documentaries on the world of medicine being produced by the Los Angeles County Medical Association. Additional financial support is being requested from other state societies and the Ford Foundation. If the project is then carried out, the programs could be made available by the Society to Wisconsin television stations.

On motion of Doctors Dettman–JJFoley, carried, the Council authorized a $1,000 appropriation for this project.

The committee also approved a $100 contribution to "Friends of WHA" which produces the *March of Medicine* program, and voted a "special merit award" to Doctor Egan for his valued service on the Finance Committee.

18. Report of Committee on Economic Medicine

A. Travel Accident Insurance

On motion of Doctors Schmidt–Beilman, carried, the Council reconsidered its February action and adopted the committee's recommendation that all benefits of the modified program be payable either to the designated beneficiary or estate, with none payable to the Society.

B. Other

The committee reported it is continuing consideration of key man insurance, professional liability and disability insurance, and will look into group no-fault automobile insurance as suggested by the insurance consultant.

19. Miscellaneous

A. Dane County Medical Society Resolution

A resolution presented by Doctor Beilman concerning care for Medicare patients in nursing homes was referred to the Executive Committee of the Council for follow-up and report back to Dane County.

B. Oconto County Medical Society Resolution

A resolution presented by Doctor Heinen concerning abolition of the AMA Council on Drugs and the publi-

cation "Drug Evaluations" was referred to the AMA delegation.

C. Annual Meeting Dates

It was proposed that the 1975 meeting, previously scheduled by House action for Madison, be held in Milwaukee when it is expected new convention facilities will be available, and that the Madison meeting be delayed until 1976, the bicentennial year. This was acceptable assuming that the proper facilities are available at the appropriate time, and should be acted upon by the House of Delegates in 1974.

D. Nurse Clinician

John U. Peters, MD, of Fond du Lac, discussed briefly a masters degree program at the UW–Oshkosh which will produce a nurse clinician who will do primary care. This was referred to the Commission on Public Policy.

20. WPS Separate Incorporation

On motion of Doctors Behnke–TJFoley, carried, this subject was discussed in executive session.

On motion duly made, seconded and carried, the Council recommended that "no action" be taken by the House of Delegates on Recommendation C submitted at the request of the Council as a part of Report No. 13.

21. Adjournment

The meeting adjourned at 6:00 p.m.

EARL R. THAYER
Secretary

Approved: May 10, 1973
EUGENE J. NORDBY, MD
Chairman

COUNCIL MINUTES—State Medical Society of Wisconsin

MILWAUKEE, MARCH 25, 1973

A special meeting of the Council was called to order by Chairman Nordby at 9:15 a.m. at the request of the Secretary and General Manager for clarification of the action taken in executive session on Saturday. All voting members were present except Doctors Egan and Pittelkow.

Actions:

Motion of Doctors Heinen–Smejkal, carried, to rescind the action taken in executive session on March 24, 1973.

Motion of Doctors Purtell–Behnke, carried, to approve Executive Committee action reaffirming the fact that the Secretary is the General Manager of all of the activities of the State Medical Society of Wisconsin and its divisions, and amending the action taken by the Council on November 14, 1970, as follows: "The Insurance Director shall report to *and be accountable to* the general manager to permit the latter's informed reporting required in his function and to allow an overview of the financial operations and of the personnel practices and compensation of WPS so as to insure consistency with Society policies and with the operation of other Society activities and functions."

The meeting adjourned at 10:40 a.m.

EARL R. THAYER
Secretary

Approved: May 10, 1973
EUGENE J. NORDBY, MD
Chairman

COUNCIL MINUTES—State Medical Society of Wisconsin

MILWAUKEE, MARCH 27, 1973

1. Call to Order and Roll Call

The meeting was called to order at 10:50 a.m. on Tuesday, March 27, 1973, at the Pfister Hotel in Milwaukee, following adjournment of the House of Delegates.

Voting members present: Doctors JJFoley, Olsman, Nordby, Huth, Beilman, Edwards, Smejkal, Mauthe, McKenzie, Rohde, Heinen, Lewis, Manz, Doyle, LaBissoniere, Williams, TJFoley, Schmidt, Meyer; Past President Purtell, President Derus, and Speaker Hamlin.

Others present: President-elect Dettmann, Vice-speaker Stuff, Treasurer Weston; AMA delegates and alternates Bell, Galasinski, Picard, Dessloch, Carlson, Twelmeyer, and Kief; Messrs. Thayer, Koenig, Maroney, Johnson, Graham, Bontrager, Sutherland; Mrs. Anderson and Miss Pyre.

2. Oath of Office

The oath of office was administered to Doctors Dettmann, Stuff and McKenzie by Chairman Nordby.

3. Council Elections

By various motions duly made, seconded and carried, the following were nominated and elected for the ensuing year:

Council Chairman: E. J. Nordby, MD, Madison
Vice-chairman: D. K. Schmidt, MD, Milwaukee
Society Treasurer: F. L. Weston, MD, Madison
Assistant Treasurers: H. Kent Tenney, MD, Madison
A. A. Quisling, MD, Madison
N. A. Hill, MD, Madison
J. T. Sprague, MD, Madison
Max M. Smith, MD, Madison
Editorial Director, WISCONSIN MEDICAL JOURNAL:
Raymond Headlee, MD, Elm Grove

The Council also elected a non-medical member of the CES Foundation board of trustees, subject to his acceptance.

4. WPS Separate Incorporation

Chairman Nordby pointed out that with passage of a resolution by the House of Delegates authorizing incorporation of WPS as a stock insurance corporation under Chapter 611, the next step would be for the attorneys to prepare the necessary papers for submission to the Insurance Commissioner, and that the Council would be kept informed.

Question was asked whether the Society and WPS would appear at the forthcoming hearing in reference to proposed Chapter 613 relating to the Blue plans. Mr. Koenig indicated that he expected the same points would be pursued at the insurance laws revision committee hearing as had been communicated to Dean Kimball.

5. Council Organization and Meeting Dates

The chairman announced appointments to component committees of the Council and said that these would be distributed to councilors.

He proposed the following dates for regular Council meetings, suggesting that the Council return to two-day weekend meetings unless the agenda does not demand it:

July 14–15; November 10–11 (since changed to November 3–4 because of a conflict); January 26–27; and March 23 preceding the 1974 annual meeting.

The January date is two months before the annual meeting, when the nominating committee will also be holding an open session at the Society.

6. Various Appointments

J. W. McRoberts, MD, Sheboygan, was reappointed as the Society's representative on the board of directors of the Wisconsin Regional Medical Program.

W. P. Curran, MD, Antigo, was nominated for reappointment by the Governor to the State Board of Nursing.

A panel of four nominees was approved for consideration of an appointment by the Governor to the hearing aid dealers board.

W. D. James, MD, Oconomowoc and Rodrigo Munoz, MD, Sheboygan, were reappointed as advisors to the American Association of Medical Assistants—Wisconsin Society.

7. Possible AMA Resolutions

Doctor Galasinski reported that actions of the Council and House of Delegates just concluded indicated the following as subjects to be considered for AMA resolutions:

A. AMA Committee on Medical Aspects of Automotive Safety

A resolution requesting reactivation of this committee was not adopted by the House, but was referred to the AMA delegation.

On motion of Doctor Williams, seconded and carried, the Council advised that the delegates do with it as they see propitious.

B. AMA Drug Evaluations

The Council had referred to the AMA delegation a resolution presented by Doctor Heinen requesting that the AMA reestablish its Council on Drugs with the view to continuing periodic revision and publication of "AMA Drug Evaluations."

NOTE: It has since been ascertained that the AMA intends to continue this publication, and the second edition will be ready in August 1973.

C. National Health Service Corps

The Special Committee on Shortage of Physicians and the House of Delegates had made certain recommendations concerning the recruitment of physicians through the National Health Service Corps to be transmitted to the AMA and Congress.

On motion of Doctor Olsman, seconded and carried, the Council authorized preparation of a resolution embodying the recommendations, including provision that the curriculum vitae of NHSC physicians be cleared in advance of their placement with an appropriate local medical group in the particular area.

8. Legislation

A. AB 490—Standards for Health Insurance

The Council was informed that substantial opposition to this bill was expected from the insurance industry generally, including that of the Commission on Medical Care Plans with regard to several specific areas of concern to WPS.

B. SB 253—Premium discount to insureds who obtain an annual physical examination

The Commission on Medical Care Plans recommends no position at this time.

C. AB 489—Health Services Commission

Doctor Derus solicited the thoughts of Council members as to reasonable approaches to be taken in communicating the opposition of medicine to the health services commission concept.

9. William J. Egan, MD

On motion of Doctor Purtell, variously seconded and carried, the Council asked that a resolution of appreciation be presented to Doctor Egan for his years of service to the Society in so many ways.

10. Adjournment

The meeting adjourned at 11:30 a.m.

EARL R. THAYER
Secretary

Approved: May 10, 1973
EUGENE J. NORDBY, MD
Chairman

□

WISCONSIN PROGRAMS CONCERNED WITH TREATING NARCOTIC ADDICTION AND DRUG ABUSE: This information is available from the Division of Mental Hygiene, State Department of Health and Social Services, 1 West Wilson St., Madison, Wis. 53702; tel. (608) 266–1083.

NEWS HIGHLIGHTS

Health Manpower Utilization Study Planned

The Health Economics Research Center of the University of Wisconsin in affiliation with Marc F. Hansen, MD,* assistant dean of the UW Medical School, is conducting a study on health manpower utilization. Goals of the study are to determine the alternative methods by which health care is and can be delivered and to determine future health manpower needs and training requirements.

The study employs direct observation of medical practices throughout the country. Ten first-year medical students have been selected to serve as medical observers this summer. The role of the observer is to accompany patients throughout the medical practice, timing and recording the medical tasks performed and the person delivering the medical care. Observations will be conducted for two weeks per practice.

UW Medical School Teaching Awards Granted

Two physicians were honored for their teaching of medical students when the University of Wisconsin–Madison Medical School and University Hospitals held their annual recognition ceremony May 18.

Emeritus Dean William S. Middleton, MD,* Madison, received the Distinguished Teaching Award and Erik G. Pingoud, MD, Madison, was presented the Distinguished Teaching by a Resident Award. Citations are presented by the Wisconsin Medical Alumni Association to winners of an annual balloting by the senior medical class.

Doctor Middleton also received the award in 1969. He joined the medical school faculty in 1912 and was dean from 1935 to 1955 when he retired at the age of 65 and for eight years was chief medical director of the Veterans Administration in Washington. He is the recipient of numerous international and national honors, including an honorary doctorate degree from UW–Madison in 1971.

Doctor Pingoud is a second year resident in medicine at University Hospitals. Born in Kaven, Lithuania, he received his medical degree from the University of Tubingen Medical School in Germany and interned at the University of Ulm in Germany before coming to Wisconsin.

Name Recent Fellows in Anesthesiology Group

The April Newsletter of the American College of Anesthesiologists announced that the following Wisconsin members were recently certified as Fellows of the ACA: MDs Primitivo I. Reynaldo* of Wauwatosa, Ronald W. Stein* of Colgate, and Shamrao Vaidyanath* of Madison. The Newsletter also announced that the 1974 College Written Examination will be held in various locations on Saturday. Feb. 2, 1974. Deadline for receipt of credentials for this examination is Nov. 2, 1973. Applications and information may be obtained by writing to the ACA, 515 Busse Highway, Park Ridge, Ill. 60068.

Doctors to Staff Two Medical Clinics

MDs Renato R. Baylon* and G. B. Mejia,* who currently practice in the Crossroads Health Center, located at the intersections of highways 82, 51, and 23 in Marquette County, are making plans to expand their services to the Montello Clinic which opened last fall but has not had a practicing physician on its staff. A third doctor is expected to join the clinics soon.

PHYSICIAN BRIEFS

William A. Kretzschmar, MD*

. . . Whitefish Bay, recently was installed as president of the Milwaukee Gynecological Society at its annual meeting, succeeding William W. Baird, MD,* Wauwatosa. The Society is composed of 125 board certified and board eligible obstetricians and gynecologists in Wisconsin. It meets at the University Club in Milwaukee in October, November, February, March, and April. William C. Fetherston, MD,* Milwaukee, was chosen president-elect; David V. Foley, MD,* Wauwatosa, was reelected secretary–treasurer. Robert H. Herzog is the executive secretary.

Gerald I. Uhrich, MD*

. . . La Crosse, recently was elected president-elect of the American Association of Railway Surgeons at its meeting April 27 in Chicago. Doctor Uhrich will take office as president in April 1974.

Richard H. Wasserburger, MD*

. . . professor of medicine at the University of Wisconsin–Madison Medical School, was made an honorary firefighter by the City of Madison Fire Department April 19 for his participation in the Emergency Medical Services Training Program at University Hospitals. Firefighter Phil Behrend (right) presented the symbolic firefighter's hat to Doctor Wasserburger during graduation ceremonies for six trainees. The program, which was begun in September 1972, had graduated 15 firefighters as of April.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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La Crosse Society Hears Doctor Kimmey

Members of the La Crosse County Medical Society in April heard James R. Kimmey, MD (center) explain Governor Patrick J. Lucey's package of health-care legislation and its implications for the medical profession. Doctor Kimmey heads the State Health Policy and Program Council. With him are Joseph Durst, MD* (left), county society president, and Robert Green, MD,* president-elect. (LA CROSSE TRIBUNE Photo)

Marquette–MCW Medical Alumni Association Honors

John S. Hirschboeck, MD,* a 1937 alumnus of Marquette University School of Medicine and its former dean, was honored as the 1973 Alumnus of the Year at the Marquette–MCW Medical Alumni Association annual dinner meeting March 24 in Milwaukee. Doctor Hirschboeck currently is coordinator of the Wisconsin Regional Medical Program. He served as dean of the medical school from 1947 through 1965. Joseph S. Devitt, MD,* Class of '38, outgoing president of the alumni association, was presented with a plaque in recognition of his service during the past year. John O. Chamberlain, MD,* Class of '52, was installed as president.

UW Medical Alumni Group Elects Officers

G. Stanley Custer, MD* of Marshfield was named president-elect of the Wisconsin Medical Alumni Association at its annual Alumni Day meeting May 18 on the University of Wisconsin Center for Health Sciences campus in Madison. He will take office on Alumni Day next year. Doctor Custer is a 1942 graduate of the UW Medical School and practices internal medicine at the Marshfield Clinic.

Two directors were elected and took office immediately. They are: Edward B. Miner, MD* of La Crosse, an internist, and William T. Russell, MD,* a Sun Prairie family physician. Doctor Miner is a 1957 UW Medical School graduate and Doctor Russell received his MD degree there in 1946.

Loron F. Thurwachter, MD,* an anesthesiologist residing in Whitefish Bay, succeeded Louis C. Bernhardt, MD,* a general surgeon in Madison, as president at the meeting.

Winnebago Doctors Hear About Prepaid Medical Insurance

James Dyer, director of health protection at Employers Insurance of Wausau, addressed members of the Winnebago County Medical Society on the subject, "Prepaid Medical Insurance," when they met in April in Menasha.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1973

1 Dane County Medical Society Board of Trustees, Public Relations Committee and Public Health Advisory Committee
1 Madison Urological Society
1 Madison Anesthesiology Society
2 Board of Directors, Madison Chapter of American Management Society
3 Dane County Medical Society Ad Hoc Committee on Foundations
5 Wisconsin College Health Association
7 Dane County Medical Society Insurance Advisory Committee
9 SMS Commission on Safe Transportation
9 SMS Committee on Grievances
10 Dane County Medical Society Public Health Advisory Committee
10 Executive Committee of of SMS Council, SMS Council, and SMS Commission on Medical Care Plans
10 Madison Academy of Internal Medicine
11 SMS Ad Hoc Committee on Chiropractic
12 AMA Midwest Regional Conference on Chiropractic (Edgewater Hotel, Madison)
12 Board of Directors, Wisconsin Health Care Review, Inc.
17 SMS Committee on Medicine and Religion
23 State Pharmacy Board Exams
23 Subcommittee on Planning Annual Meeting, SMS Commission on Scientific Medicine
30 SMS Commission on Public Policy
30 Board of Directors, WISPAC
30 County Chairmen, WISPAC, and CHECKPOINTS/CHECKMATES

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

PHYSICIAN BRIEFS . . .

Doctor Graven

Stanley N. Graven, MD*

. . . director of the University of Wisconsin–Madison's neonatal program, was honored by the Wisconsin Chapter of the American Academy of Pediatrics at its annual meeting in Oshkosh in May. Doctor Graven was presented the Chapter's first award for outstanding contributions to the welfare of Wisconsin children. He was selected by a committee from nominations made by chapter members, according to John R. Guy, MD* of Waukesha, chairman of the state chapter. Doctor Graven is a professor of pediatrics at the UW–Madison Medical School.

J. Robert Turner, MD

. . . Princeton, recently took over the medical practice of G. G. Mueller, MD* who is retiring. Doctor Turner graduated from the University of Iowa in 1966 and spent one year in research in the Renal Dialysis Program at the Veterans Administration Hospital, Iowa City, in addition to doing research in pharmacology, laboratory medicine, and clinical subjects. Prior to coming to Princeton, he was associated with a group of physicians in Clinton, Iowa.

Andrew E. Cyrus, Jr., MD*

. . . Milwaukee, president of the Multiple Sclerosis Society of Milwaukee, recently received the Dale Carnegie Alumni Association Good Human Relations Award.

NEWS HIGHLIGHTS . . .

WTRDA Changes Its Name; Elects Officers

At its recent 1973 Annual Meeting the Wisconsin Tuberculosis and Respiratory Disease Association (WTRDA) changed its name to Wisconsin Lung Association (WLA). This is the second updating of its name in the 65-year history of the group, chartered in 1908 as the Wisconsin Anti-Tuberculosis Association. In 1969 it switched to WTRDA. Members say the new name directly and accurately reflects the organization's present field of interest. It also will be easier for people to recognize and remember.

Benjamin G. Narodick, MD* of Milwaukee is the immediate past president of the association. John P. Gwin of Beloit is the new president. R. P. Jahn, MD,* Milwaukee, is medical director. MDs holding offices in WLA are: Larry A. Lindesmith,* La Crosse, second vice-president; Nicholas L. Owen* and Donald P. Schlueter,* Milwaukee, newly elected members of the board of directors; Oscar A. Farias,* Hawthorne, and James M. Wilkie,* Madison, reelected members of the board. Other MD members of the board are: Henry A. Anderson* and Helen A. Dickie* of Madison. Three MDs retired as directors at this meeting: Edward A. Bachhuber,* Elwood W. Mason,* and George C. Owen,* all of Milwaukee.

The Wisconsin Thoracic Society, medical section of the WLA, elected Edward F. Banaszak, MD* of Milwaukee as its president; Louis W. Chosy, MD* of Madison, vice-president; and Leonard W. Worman, MD,* Milwaukee, secretary.

The Wisconsin Lung Association's 1973 Distinguished Service Award was presented to Oscar A. Sander, MD,* Milwaukee, who has had "one of the longest and most distinguished careers of service in association annals."

Milwaukee Academy of Medicine Meets

At its May 15 meeting the Milwaukee Academy of Medicine heard Scott N. Swisher, MD, professor and chairman of the Department of Medicine, Michigan State University, discuss "Some Newer Biological and Clinical Aspects of Autoimmune Hemolytic Anemia." The Academy's next meeting will be held Tuesday, October 16, at the University Club of Milwaukee. The Academy office will be closed for vacation from August 3 to September 4.

Winnebago Society Has Brazilian Guest

Sixty-two members of the Winnebago County Medical Society met May 3 in Oshkosh. They heard a slide talk on "Medical Experiences on the SS HOPE in Brazil," by John B. Wear, Jr., MD,* chief of the Department of Urology, University Hospitals, Madison. A guest at the meeting was Joao Cabral, MD, chief of urology at the Medical School of Rio Grande, de Nort, Brazil.

Pathologists Set Fall Meeting

The Fall Meeting of the Wisconsin Society of Pathologists will be held Saturday, October 6, at Bellin Memorial Hospital in Green Bay. Local host will be Marvin D. Blackburn, Jr., MD,* president-elect of the Society.

The morning program will include a discussion on the basic science aspects of the skin. A short business meeting is being planned for either before or after the luncheon. The afternoon program will be a seminar on skin pathology, moderated by Elson B. Helwig, MD, of the Armed Forces Institute of Pathology, Washington, D.C. A Society dinner also is being planned. □

Doctor Hofmeister

Frederick J. Hofmeister, MD*

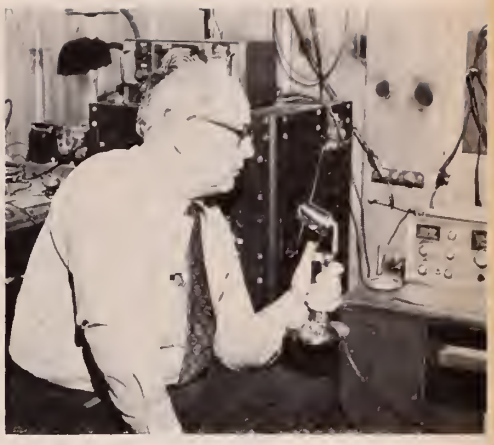
. . . Wauwatosa, associate clinical professor of obstetrics and gynecology at the Medical College of Wisconsin was named president-elect of The American College of Obstetricians and Gynecologists (ACOG) at its 21st Annual Clinical Meeting May 22 in Bal Harbour, Fla. Doctor Hofmeister is a member of the attending staff and past chairman of the Department of Obstetrics and Gynecology at Lutheran Hospital, Milwaukee. In 1968 he was president of the Central Association of Obstetricians and Gynecologists and in 1970 he received the first Distinguished Service Award of the ACOG. Since 1951 he has been a member of the State Medical Society of Wisconsin's Maternal Mortality Study Committee and from 1969–1973 he was chairman of the Society's Division on Maternal and Child Welfare of the Commission on State Departments. Presently he is vice-chairman of the Advisory Board of the Salvation Army in Milwaukee and the Medical Advisory Committee of Planned Parenthood of Wisconsin.

William F. Schorr, MD*

. . . Marshfield dermatologist, spoke about "What's New in Contact Dermatitis" at a conference on "Advances in Dermatology, 1973" presented in May by the Cleveland Clinic Foundation. Doctor Schorr is one of thirteen dermatologists of the North American Contact Dermatitis Research Group devoted to standardizing and advancing allergy testing in dermatology.

Harold P. Rusch, MD

. . . who has spent his entire career fighting cancer and in the process has helped make the University of Wisconsin a major cancer center, was honored by his alma mater May 18 in Madison. Doctor Rusch received the 16th Alumni Citation at the University of Wisconsin–Madison Medical School Alumni Day. A 1933 UW medical school graduate, Doctor Rusch is director of the new Wisconsin Clinical Cancer Center at the University's Center for Health Sciences. He was selected for the honor by the medical alumni association's board of directors from a list of alumni who have made outstanding contributions to medicine as compiled by emeritus professors.



Dr. Stack—a ham radio operator

Edward G. Stack, Jr., MD*

. . . Superior, recently was pictured "hard at work" with his 20-meter ham radio. Doctor Stack, a ham radio enthusiast for over 20 years, communicates with other ham amateurs as far away as Finland, Australia, England and the Arctic Region. (Photo courtesy of SUPERIOR EVENING TELEGRAM)

Robert W. Adams, MD*

. . . Chetek, recently was selected as the City of Chetek "Citizen of the Month" for April 1973. Doctor Adams, cited for his many years of unselfish and tireless service to the area, retired in 1966 after serving the area since 1926. He was honored at the State Medical Society's Annual Meeting this March, as being one of the 29 physicians inducted into the "50-Year Club" of the Society.

▲ Milwaukee Psychiatric Hospital { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ Milwaukee Sanitarium { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ Dewey Center { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

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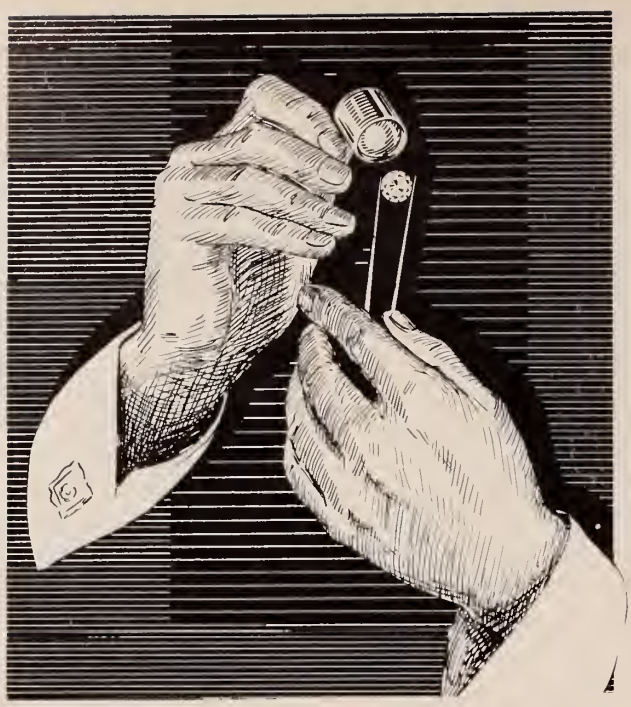

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PHYSICIAN BRIEFS . . .

Charles L. Weisenthal, MD*

. . . of Milwaukee has been appointed as the official delegate of the Wisconsin Urological Society to the State Medical Society of Wisconsin. He succeeds John W. Kearns, MD* of Milwaukee. Francis I. Andres, MD,* Wauwatosa, is the alternate delegate.

Robert A. Bonebrake, MD*

. . . head of the rheumatology department at the Jackson Clinic in Madison, discussed medical treatment of arthritis at a free public forum on Arthritis at the April 12 meeting of the Richland Center Senior Citizens group. It was sponsored as a public service by the Southern District of the Arthritis Foundation of Wisconsin. Doctor Bonebrake is vice-chairman of the Southern District.

William S. Middleton, MD*

. . . emeritus dean of the University of Wisconsin Medical School, Madison, recently was honored by having his new book, "Values in Modern Medicine," cited for its scholarly work. It received the runner-up award for 1972 from the Council for Wisconsin Writers. The book was published last fall by the UW Medical Alumni Association and the University Press.

William H. Keeler, MD*

. . . assistant clinical professor of preventive medicine at the Medical College of Wisconsin, Milwaukee, and a general practitioner, has been appointed associate director of the St. Michael Family Practice Residency Program. He assists Norbert G. Bauch, MD,* director of the program, in the instruction of residents.

Leo B. Grieben, MD*

. . . Eau Claire, recently resigned his position of medical director of the Eau Claire County Hospital. Doctor Grieben will retain his consultative role with the institution but intends to dedicate more of his time to private practice and other community activities.

Richard D. Sautter, MD*

. . . Marshfield, recently participated in the National Symposium on Pulmonary Thrombo-embolism sponsored by the University of Kentucky Medical Center. The subject of his talk was "Massive Pulmonary Embolism–Fibrinolytic Therapy."

Charles C. Lobeck, MD*

. . . Madison, recently was the conference chairman of the Sixth International Cystic Fibrosis Congress held in Washington, D. C. Doctor Lobeck is associated with the Department of Pediatrics at University Hospitals, Madison.

William P. Wendt, MD*

. . . Elm Grove, recently was elected chief-of-staff at Lutheran Hospital, Milwaukee. He succeeds Christopher R. Dix, MD,* Elm Grove, who served for three years. Robert A. Kebbekus, MD,* Wauwatosa, was elected vice chief-of-staff.

Sang B. Lee, MD*

. . . Chippewa Falls, recently opened his office for the practice of obstetrics and gynecology. Doctor Lee is a graduate of Chunnam University, Korea, and served for four years in the Korean Army as an army surgeon. After service he interned at the Huron Road Hospital, East Cleveland, Ohio, and took residency training at St. Thomas Hospital, Akron, Ohio.

Hania W. Ris, MD

. . . member of the clinical faculty of the Department of Pediatrics, University of Wisconsin Medical School, Madison, and medical director of the Wisconsin School for Girls, Oregon, attended the Upper Midwest Conference on Health Care in Correctional Institutions, April 1–3, in Minneapolis, Minn. Sponsored by the Minnesota Department of Corrections and the University of Minnesota, the three-day conference was designed to explore the special problems faced by health care personnel in correctional institutions and to set up a system of communication between personnel in different institutions. Doctor Ris presented a paper, "How to Render High Quality Comprehensive Care to Institutionalized Youth in Spite of Obstacles."

Adolf Stafl, MD*

. . . assistant professor of gynecology and obstetrics, Medical College of Wisconsin, Milwaukee, is co-author of a new book, "Atlas of Colposcopy." His associate in this work is Per Kolstad, MD, professor of gynecology at the University of Oslo, Norway.

Stanley L. Inhorn, MD*

. . . Madison, director of the Wisconsin State Laboratory of Hygiene and professor of medicine at the University of Wisconsin Medical School, recently spoke on "Mycoplasma Infection and Clinical Illness" to the medical staff of St. Francis Hospital, La Crosse. □

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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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To help you manage excessive psychic tension

OBITUARIES

John O. Hadley, MD, 48, Pueblo, Colo., and his wife, Doris, died Apr. 4, 1973 in a plane crash near Pueblo, Colo.

Born on Mar. 25, 1925 in Ottawa, Ill., Doctor Hadley graduated from the University of Illinois Medical School in 1951 and served his internship at Milwaukee County General Hospital. He served in the United States Army Air Force during World War II. Doctor Hadley practiced in Watertown, Wis., from 1952–1956 and continued his education until 1959 when he started medical practice in Pueblo, Colo.

Surviving the couple are five children; John, 22, Pueblo; James, 20, a student at Colorado State University; Joan, 19, a student at Southern Colorado State College; Judith, 12, and Jean, 10, at home.

Elizabeth R. Baldwin, MD, 62, former Marshfield physician and city health officer, died Apr. 23, 1973 in Port Charlotte, Fla.

Born on July 3, 1910 in Milwaukee, Doctor Baldwin graduated from the University of Wisconsin Medical School in 1935 and served her internship at Wisconsin General Hospital, Madison, and St. Joseph's Hospital in Marshfield. Doctor Baldwin

SPECIAL

Position Statement on the Clinical Nurse Specialist in the State of Wisconsin

Rationale*

The current development of the clinical nurse specialist role stems from the increasing need and demand for quality nursing care in a variety of health care settings. Several factors have provided stimuli for the change of health care delivery systems and a new role for the professional nurse. Included among these factors are rapid technological, clinical and theoretical advances; increasing numbers of persons requiring a variety of health services; new methods of health care delivery; demand by the public for quality health care; emphasis on prevention of dysfunction and maintenance of mental and physical health; and a movement within the nursing profession to improve delivery of nursing care.

Leadership in nursing practice is essential. This leadership is needed to provide a clinical role model to continually improve nursing practice and to create new dimensions in the diagnosis, intervention and evaluation of health needs. The clinical nurse specialist has been prepared at an academic level which stresses the importance of the integrative aspects of nursing care and methods of implementing care within the clinical specialty. Thus, the clinical nurse specialist is the ideal person to assume leadership as liaison between theoretical constructs and nursing practice.

In summary, it can be stated that the clinical nurse specialist with extensive preparation in theoretical and practical aspects of patient care, knowledge of methods and techniques of research and leadership capabilities is the most appropriately qualified person to stimulate and promote quality nursing practice to meet the consumer's need to have expert nursing knowledge and capability available to him directly.

Definition

A clinical nurse specialist is a registered nurse who holds a masters degree with emphasis in clinical nursing and who demonstrates a high degree of professional competence in his/her practice within a specialized field of nursing.

Responsibility and Functions

The major responsibility of the clinical nurse specialist is the management and innovative improvement of nursing care for a selected group of patients. Within a given setting, the clinical nurse specialist is responsible directly to the person who administratively represents nursing practice. In some health settings, the clinical nurse specialist is the representative of nursing practice.

The primary responsibility of the clinical nurse specialist is to the consumer. To fulfill this responsibility he/she would be expected to function as a: practitioner . . . educator . . . consultant . . . researcher. . . .

* Major portions excerpted from New York State Nurses Association with permission: "Position Statement on the Clinical Nursing Specialist."

—Approved by Wisconsin Nurses Association Board of Directors Oct. 3, 1972
—Adopted by Clinical Nurse Specialist Group of Wisconsin Nurses Association

joined the staff of the Marshfield Clinic in 1940 and when her husband, the late Robert S. Baldwin, MD, entered the Army, she moved to Highland Park, Ill., and practiced there until 1945. She returned to the Marshfield Clinic in 1945 and practiced there until 1949 when she opened her own office. Doctor Baldwin was appointed city health officer of Marshfield in 1953 and in 1957 she held the distinction of being the first woman doctor to be appointed to the Wisconsin State Board of Health, a position she held until 1964.

Doctor Baldwin, who has made her permanent home in Punta Gorda, Fla., since 1967, was the assistant director of the Hendry County Health Department and served as emergency room physician at a Punta Gorda hospital.

She was a member of the American Academy of Family Physicians, American Woman's Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are four children; Mrs. Martha Loverde, New York City; Navy Cmdr. Edwin (Mac) Baldwin, Idaho Falls, Idaho; Dr. Stanley Baldwin, Dayton, Ohio; and Dr. Grace Letton, Boston.

Alphons E. Bachhuber, MD, 70, Kaukauna physician for nearly 40 years, died Apr. 23, 1973 in Appleton.

Born on July 24, 1902 in Mayville, Wis., Doctor Bachhuber graduated from Johns Hopkins University Medical School in 1926 and served his internship at Women's Hospital in Baltimore and did postgraduate work at the University of Vienna in Austria. From 1927–1932 he practiced with his father, Dr. Alphons E. Bachhuber, Sr., in Mayville, Wis., and in 1932 started a practice in Kaukauna until his retirement in 1971. His brother, Doctor Alois Bachhuber, joined him in practice and together they developed the first clinic in town.

Surviving are his widow, Priscilla; three daughters, Mrs. Barbara B. Van Lanen, Madison; Mrs. Robert T. (Pauline) Constable, Westchester, Pa.; and Mrs. Ralph G. (Jane) Petrie, Fond du Lac; and four sons, Alphons E., Jr., Sarasota, Fla.; John J., Appleton; Mark, Plymouth; and Capt. David, Fort Hood, Tex. Also surviving is a brother, Dr. Edward A. of Milwaukee; another brother, Dr. Francis G. of Mayville, preceded him in death. □

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF APRIL 13, 1973

NEW MEMBERS

Alwa, Rathan, 1233 North 22nd St., Milwaukee 53205
Beckner, Thomas F., III, 615 South 10th St., La Crosse 54601
Belgea, Kathy P., 1615 Maple Lane, Ashland 54806
Bjarnason, David F., 630 South Central Ave., Marshfield 54449
Brown, Garfield W., 1001 West Second St., Ashland 54806
Cooley, Richard L., 401 North Oneida St., Appleton 54911
Dennis, Susana R. K., 506 North Walnut St., Madison 53705
Fischer, Markhan J., 1615 Maple Lane, Ashland 54806
Greenberg, Earl B., 1912 Atwood Ave., Madison 53704
Gulshan, Bhag S., 131 East Chateau Place, Whitefish Bay 53217
Harlan, William L., R.F.D. #2, Monroe 53566
Ice, Anne-Mare, 1616 West Wisconsin Ave., Milwaukee 53233
Jackson, Pauline M., 1836 South Ave., La Crosse 54601
Kafura, Peter J., 11929 Diane Road, Wauwatosa 53226
Lee, Ha-Gun, 1515—10th St., Monroe 53566
Miller, Robert C., 337 West Wisconsin Ave., Tomahawk 54487
Murphy, M. John, 1836 South Ave., La Crosse 54601
Nair, Velayudhan K., 1515—10th St., Monroe 53566
Nichols, Charles P., 709 South 10th St., La Crosse 54601
Ostrow, David E., 811 East Washington Ave., Milwaukee 53204
Peters, Terrence E., 1515—10th St., Monroe 53566
Raine, Charles H., 2405 Northwestern Ave., Racine 53404
Resan, Thomas K., P.O. Box 549, Woodruff 54568
Rice, Paul R., 1962 Greentree Rd., West Bend 53095
Schiek, Irving E., III, Schiek Plaza, Rhinelander 54501
Schwartz, Henry J. C., P.O. Box 549, Woodruff 54568
Seidel, Barry J., P.O. Box 549, Woodruff 54568
Silberman, Richard E., 1120 North 119th St., Milwaukee 53226
Singh, Satnam, 4027 Erie St., #204, Racine 53402
Skemp, Frederick C., Jr., 815 South 10th St., La Crosse 54601
Soucheray, Philip H., La Pointe 54850
Spernoga, John F., 26 Bayfield St., Washburn 54891
Traul, Don G., 1515—10th St., Monroe 53566
Trudeau, David L., Washburn 54891
Zamora, Alfredo P., Jr., 1469 South 70th St., West Allis 53214
Zarwell, David H., 812 West Janice Court, La Crosse 54601

CHANGE OF ADDRESS

Anderson, Alton D., 2 West Gorham St., Madison 53703
Appleby, Keith B., 15155 Cascade Dr., Elm Grove 53122
Blackwood, John S., 17050 West North Ave., Brookfield 53005
Goza, George M., P.O. Box 126, Cumberland 54829
Hart, Terrence N., 17050 West North Ave., Brookfield 53005
Kent, Leslie T., 611—56th St., Kenosha 53140
Luedke, Donald M., 17050 West North Ave., Brookfield 53005
Mobarek, Yousef S., 6308—8th Ave., Kenosha 53140
Motamedi, Naghi, 836 North 12th St., Milwaukee 53233
Mueller, Karl H., 17050 West North Ave., Brookfield 53005
Paust, Joan C., 33 Ruden Place, Apt. 434, West Haven, Conn. 06516
Sewell, Robert H., 17050 West North Ave., Brookfield 53005
Wells, Marvin, 2040 West Wisconsin Ave., Milwaukee 53233

DEATHS

Nash, Charles B., Rock County, Mar. 9, 1973
Ferrou, Carlos A., Milwaukee County, Mar. 11, 1973
Hiller, Samuel J., nonmember, Mar. 13, 1973
Howard, Timothy J., Milwaukee County, Mar. 22, 1973 □

Reprints Available: Acute Infectious Nonbacterial Gastroenteritis

A limited number of reprints of the proceedings of a Combined Clinical Staff Conference at the National Institutes of Health, published in the June 1972 issue of *Annals of Internal Medicine,* are now available to interested physicians on request.

ACUTE INFECTIOUS NONBACTERIAL GASTROENTERITIS: ETIOLOGY AND PATHOGENESIS (76: 993–1008, 1972)

Studies presented in this conference point out that acute infectious nonbacterial gastroenteritis is a common syndrome of obscure cause. Although widespread epidemiological and clinical data point to an infectious cause, etiologic agents have not been recovered in the laboratory despite extensive efforts. Recent studies, employing volunteers as the experimental host, indicate that the etiologic agent of one outbreak is a small, ether-stable, acid-stable, relatively heat-stable virus present in the stools of patients acutely ill with the disease. Preliminary evidence suggests that the agent will replicate in vitro in a newly devised culture medium, human fetal-intestinal organ culture.

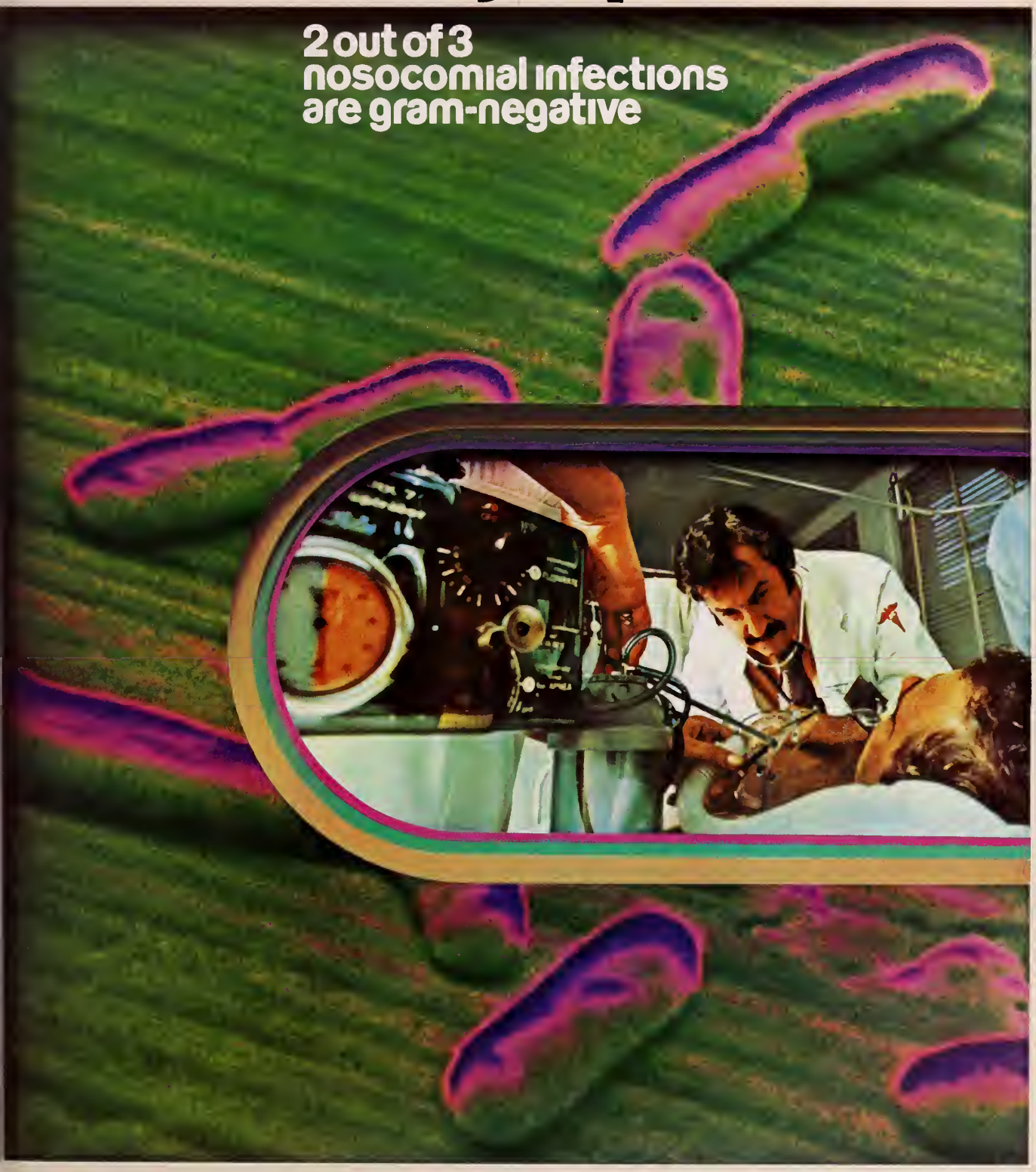
Experimental and naturally occurring cases remit spontaneously without sequels, but during the acute illness patients have transient malabsorption of D-xylose, lactose, and fat. The pathogenesis of infectious diarrheas, with respect to known bacterial pathogens and possible viral agents, is discussed. □

Discreet Diagnoses

The American Hospital Association declared that 25 to 30% of all adult medical–surgical patients in metropolitan hospitals, regardless of diagnosis, were found to be suffering from alcoholism. A study in San Francisco at the Mount Zion Hospital revealed that 50% of all fracture cases resulted from drunkenness.—PARADE □

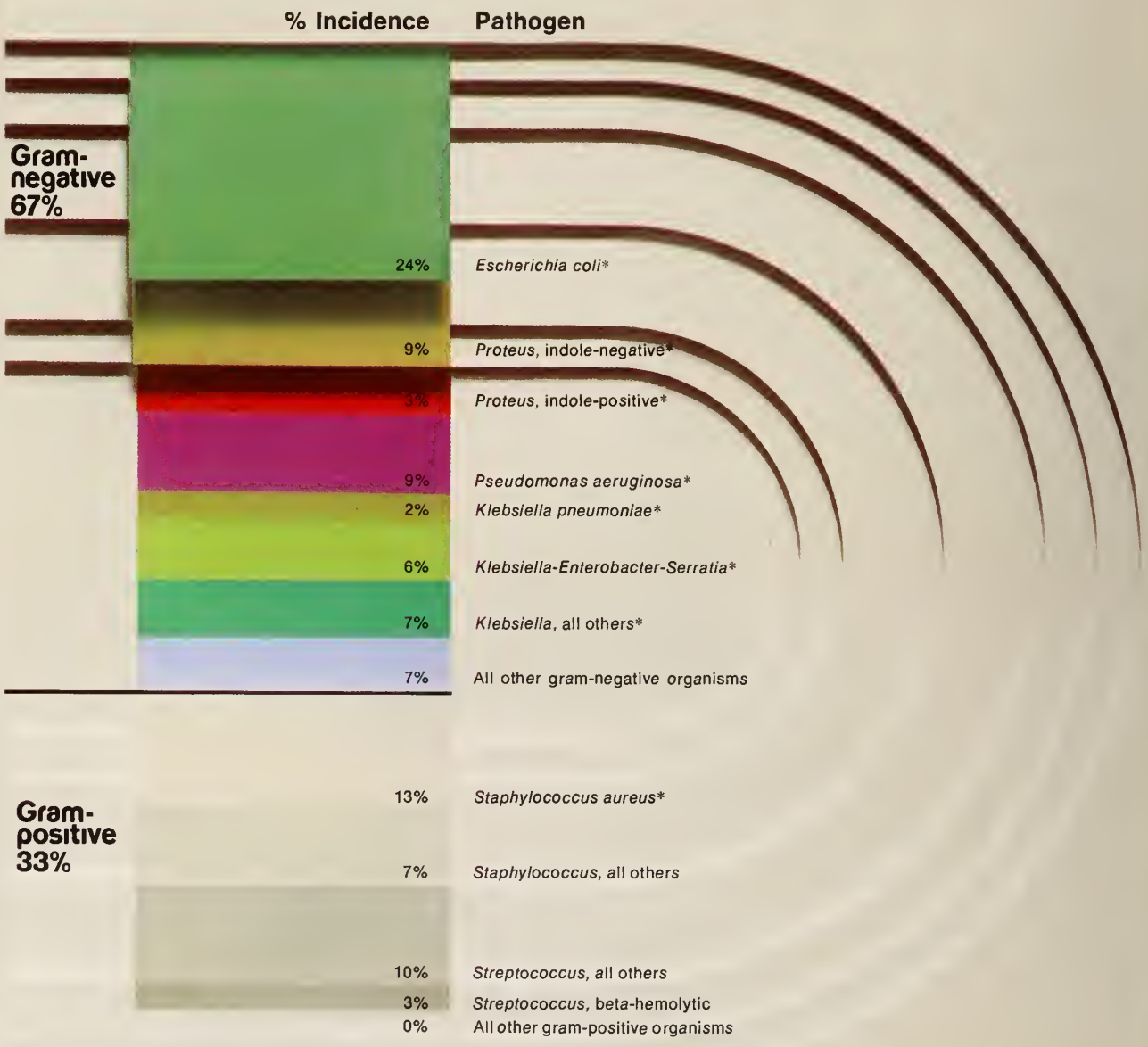
Schering

On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.

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Schering

A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella
Enterobacter } species
Serratia

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*

*Due to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services...
in hospital-acquired gram-negative infections*

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Also available:
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

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USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

*Due to susceptible organisms

SLR-301

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in two categories: PHYSICIANS EXCHANGE and COMMERCIAL. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional Insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. DISPLAY RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701; or phone (area code 608) 257–6781.

PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING: MULTI-specialty clinic in northwestern Wisconsin is expanding; group seeking

1. Internist
2. General Surgeon
3. Allergist

Ultramodern 500-bed hospital located close to clinic. Excellent recreational area. Salary first year, corporate member thereafter. Young group, incorporated, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 396 in care of the Journal. 6tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

INTERNIST NEEDED: BOARD certified or eligible. Join internist, radiologist, general surgeon, and EENT physician (all certified with another internist joining soon). Modern clinic building in university city. Population 100,000 with 3 fully equipped hospitals. Partnership opportunity after 3 years. J. B. Grace, MD, Green Bay Clinic, Ltd., 123 N. Military Ave., Green Bay, Wis. 54303. 6–8/73

WANTED: YOUNG BOARD CERtified or board eligible Obstetrician and Gynecologist to join three-man group which is part of a multi-specialty partnership (40 physicians) in a rural Midwest community serving an area of approximately 250,000. Contact Dept. 394 in care of the Journal. 5–10/73

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTItioner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $30,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

EXCELLENT OPPORTUNITY: General practitioner needed in established practice. Modern clinic adjacent to 85-bed hospital. Progressive community of 6800, excellent schools and recreational facilities. Starting salary $32,000, partnership after first year. Phone, visit or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372–4177. p4-9/73

THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine–multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Psychiatry
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 6–8/73

PHYSICIANS NEEDED: MULTIspecialty group of 24 specialists needs an:

1. Orthopedist
2. Otolaryngologist
3. Family Practitioner
4. Internist

Attractive income arrangements, association membership within 1 year, pension, and extensive fringe benefits. Excellent community of 50,000. Contact R. B. Windsor, MD, 1011 North 8 St., Sheboygan, Wis. 53081. Tel: 414/457-4461. 4-6/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

IMMEDIATE OPENING FOR:

1. Internist
2. Family Practice
3. Pediatrician
4. OB/GYN

To join young expanding group. New clinic and excellent hospital facilities adjacent to clinic. Excellent salary and partnership opportunities. New schools, churches and outstanding outside recreational activities. Contact: Lester Hirt, Box 127, Doctors for Medford, Medford, Wis. 54451. 4-6/73

EMERGENCY DEPARTMENT physician needed to join new Emergency Medical Group providing 24-hour coverage to 350-bed hospital. New Emergency Room Outpatient Department. Guaranteed minimum income. Community of over 100,000, excellent schools, state university, strong economic climate. Year-around recreational activities. Contact: Executive Director, Allen Memorial Hospital, 1825 Logan Ave., Waterloo, Ia. 50703. 6/73

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545; tel: 1–608/752–7811. 4tfn

EMERGENCY DEPARTMENT physician to join three (3) other physicians presently serving a 350-bed community hospital, located in a midwest city of 60,000 with outstanding living, recreational, and cultural facilities. Forty-hour week with competitive salary and benefits. Full specialty backup. Contact: D. E. Kershaw, St. Francis Hospital, 709 S. 10th St., La Crosse, Wis. 54601. Tel: 608/782–8022. 5–7/73

IMMEDIATE OPENINGS FOR physicians in OB–GYN specialty to establish a successful practice in a multi-specialty clinic located close to hospitals. In-clinic medical student teaching opportunity. University and college city. Year around indoor and outdoor family activities of all types. Salary plus excellent benefits first year and corporate member thereafter. Interview expenses paid. Call collect to D. W. Shea, MD, Beaumont Clinic, Ltd., 1821 S. Webster Ave., Green Bay, Wis. 54301. p5–9/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468–2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3–8/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

IMMEDIATE OPENING FOR INternist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

GENERAL PRACTITIONER WITH strong interest or background in industrial medicine needed by eleven-man multispecialty clinic. Full time or part time. Salary negotiable, many fringe benefits. Asssociate status possible after one full calendar year. Contact: Administrator, Medical–Surgical Clinic, S. C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215. 2–5/73

IMMEDIATE OPENING FOR A family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write D. Hilton, MD, President, or Russel Peterson, Business Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235–9671. 6tfn/73

WANTED: PHYSICIANS, SPECIALists or Generalists, who want to practice medicine in a semi-rural area but still have the advantages of the state's largest cultural, population, and medical center within twenty-five minutes travel.

Discover Ozaukee County. A beautiful blend of a rural agricultural setting interspersed with growing communities which are progressive but still preserve the charm and beauty of early Wisconsin history.

Physicians are urgently needed to provide the key that will open the health-care door for the 55,000 people who call this county their home. These people are more affluent than the average in Wisconsin. They need and want physicians to enjoy living and working in this area with all its advantages.

This is a prime recreation area on the shores of Lake Michigan, just north of the hustle and bustle of Milwaukee.

St. Alphonsus Hospital in Port Washington is an orderly, modern facility ready to provide acute, general hospital care in the heart of this county community. It is ideally located in the center of Ozaukee County about 20 miles from other hospitals to the north, south, and west. A new, 12-man office building connected to the hospital will be ready by August 1, 1973, and other office space is available in most of the nearby cities and villages.

If you are interested in the good life, and a good practice, contact George Seidenstricker at St. Alphonsus Hospital, 743 N. Montgomery Street, Port Washington, Wis. 53074. Tel: 414/284–5511. 6–10/73

WELL TRAINED PATHOLOGIST, AP (CP eligible), excellent references, special training in oncologic pathology, military service completed, seeks position as associate pathologist or as director. Contact Dept. 393 in care of the Journal. 4tfn/73

GET AWAY FROM THE SMOG, traffic congestion, sociological problems, crime and other irritations which have become part of today's urban living; discover Watertown, Wisconsin! Exchange all the big city unpleasantness for the peaceful environment and easy going pace of a residential city.

We urgently need family practitioners, internists and other specialties; exceptional opportunities for private or group practice growth.

Our new community health care center with its beautiful 110-bed general hospital, connecting (but separate) 24 unit medical–dental office building and connecting 120-bed nursing home, was completed in 1971.

Watertown is a progressive community, ideally located equi-distant between Milwaukee and Madison in southeastern Wisconsin's lake district; the community has a trade and medical practice area serving 40,000 people; many new schools, parks, trees, social and recreational facilities; a stable economy.

Enjoy the best of two worlds: practice in a tree-shaded medium size city with access to the medical centers at the University of Wisconsin and the Medical College of Wisconsin (formerly Marquette University School of Medicine). The medical staff is leading and supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261–4210. 3tfn/73

CAN A YOUNG FAMILY PRACTITIONER find: medical, social and economic happiness in "THE NORTH WOODS"? Soap Opera? Not quite! It's all here in Eau Claire, Wis. We're all GPs and we'll be moving in a new office. Don't blame us if you get here too late! Write: G. G. Giffen, MD, Putnam Heights Clinic, P.O. Box 970, Eau Claire, Wis. 54701. 2–6/73

GENERAL PRACTITIONER wanted to share the good life in beautiful KEWAUNEE, Wis. We can offer you, an accredited hospital, office and clinic space, crime free community, good schools, three fine churches, beautiful homes, beautiful people, Lake Michigan with its fabulous trout fishing, water skiing, boating, snowmobiling, skiing, golfing and the PACKERS. Packer Country is just 25 miles west and lastly—MONEY. Per capita income is high. We see our doctor and we pay our bills. Write to: Doctor Search Committee, P. O. Box 222, Kewaunee, Wis. 54216. 3tfn/73

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial–agricultural community with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693–3021. This ad endorsed by present doctor. 2–7/73

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325–7121. 8tfn

PRACTICES AVAILABLE

GP NEEDED TO REPLACE DEceased MD in established practice. Entire inventory for sale, excellent hospital facilities, good school in resort and recreational area. SE Wisconsin. Contact Box 457, Williams Bay, Wis. 53191. g6tfn/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

MEDICAL FACILITIES

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g4tfn/73

FOR SALE: MEDICAL BUILDING. 2100 square feet. Two divided suites. Separate, central gas heat and air conditioning. Paved parking lot. Excellent location. Residential area. Five minutes from either hospital. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634–6833. 3tfn/73

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

COMMERCIAL

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

WANTED: USED MICROSCOPES. Nicaragua/Wisconsin Partners of the Alliance have requests for used microscopes suitable for use in Nicaraguan high schools for teaching purposes. Donations to the Partners are tax deductible. Please notify Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701, if you have a usable microscope. g5tfn

PUBLICATIONS

Second National Symposium on Child Abuse. A collection of papers presented at a national meeting in Denver, Colo., Oct. 11, 1972, to explore on an interdisciplinary basis the problems of child abuse and sexual exploitation of children. Published by the American Humane Association, Children's Division, P.O. Box 1266, Denver, Colo. 80201.

CPT-3, the third edition of the AMA's Current Procedural Terminology, is now available to Wisconsin physicians at $5 per copy from the Order Department of the AMA, 535 North Dearborn St., Chicago, IL 60610. The new CPT includes more than 2,000 new and revised procedures and services and a 74-page index. 6/73

Help for the Handicapped Child. Provides clear and concise information about services for blind, deaf, crippled and retarded children and for children afflicted with allergies, arthritis, epilepsy, muscular dystrophy, heart disease, tuberculosis, leukemia, diabetes, etc. A separate chapter is devoted to each illness, in layman's words and with definitions for the important technical terms associated with it. There is some discussion as well of the prognosis of each illness, the medical progress to date and future medical goals. Author: Florence Weiner. Publisher: McGraw–Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. Price: $7.95. 6/73

Schizophrenia: Is There An Answer? DHEW publication no. (HSM) 73–9086 (printed 1972; reprinted 1973). Produced by the Center for Studies of Schizophrenia, Clinical Research Branch, Division of Extramural Research Programs, National Institute of Mental Health. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Guide for School Health Examinations. 40-page, 1970 revised edition, prepared and published by the State Medical Society's Division on School Health in cooperation with the Wisconsin State School Health Council, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, at cost of $1.00 per copy to be sent with order.

Clinical Pharmacology: A Guide to Training Programs. First detailed guide to training programs in clinical pharmacology, published by Pfizer, Inc. 105-page booklet, describes the 50 programs offered throughout the United States and Canada. Included are the clinical focus of each program, the facilities and training support available to the student, a listing of the faculty, a description of the school and application procedures.

Noting in the preface that the demand for specialists in clinical pharmacology exceeds the supply all over the world, Dr. Sheldon Gilgore, President of Pfizer Pharmaceuticals, states that the booklet is a guide for "young physicians who are looking for the challenge that clinical pharmacology will increasingly offer, both as a scientific discipline and as a very direct means of service to society."

Dr. Louis Lasagna, Director of the Department of Pharmacology and Toxicology, University of Rochester School of Medicine, writes in the introduction that well-trained clinical pharmacologists are "desperately needed" to help discover and evaluate new drugs, and that this booklet will provide "invaluable help for those who contemplate careers in this exciting discipline."

The American Society for Pharmacology and Experimental Therapeutics points out in introductory remarks that it "is pleased to see a new compendium of active training programs in clinical pharmacology" and that "the Society stands ready to encourage and help prospective clinical pharmacologists as they explore what is perhaps the most exciting area of basic science that directly relates and applies to man."

Descriptions of the various programs are written by the directors. Items covered in the booklet include names of recent graduates and their career choices as well as a selection of staff publications. It also contains a separate section on sources of support for trainees in clinical pharmacology.

Copies of the booklet will be made available to medical schools for distribution to physicians interested in pursuing a career in clinical pharmacology. A limited number of copies also are available to physicians from the Pfizer Public Affairs Division, 235 East 42nd St., New York, NY 10017.

Wisconsin Week-End. A charming little publication filled with original and informed writing about fascinating byways, historic sites, events, sports, recreational and cultural activities, museums, shops, art fairs and out-of-the-way places throughout the State. Unrivaled prescription for ennui, valuable aid to the short-trip motorist, delightful addition to your personal library or waiting room. Published 26 times yearly. Winner State Historical Society Award of Merit. Only $4 a year in Wisconsin. Wisconsin Week-End, Spring Green, Wis. 53588. 6/73

GUIDELINES FOR BLOOD–ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

COMPUTERIZED LITERATURE SEARCHES

IN

Index Medicus

NOW AVAILABLE FROM

MIDDLETON MEDICAL LIBRARY

Middleton Medical Library, University of Wisconsin, Madison, is now offering MEDLINE service free of charge to any resident of Wisconsin. MEDLINE is a computerized on-line bibliographic searching capability of the medical literature in *Index Medicus*, developed by the National Library of Medicine. Eventually, there will be a network of about 150 institutional users with individual terminals linked to the data base in Bethesda, Maryland, by long-distance telephone lines. Presently, Middleton Medical Library is the only library in the state offering this service.

Citations stored in the data base cover the period January 1969 to the present and may be retrieved by subject, author, journal, language, and date of publication.

For further information contact

Medical Library Service
Room 202
Middleton Medical Library
1305 Linden Drive
Madison, Wisconsin 53706

Or call collect (608) 262–6524

ANNOUNCEMENTS

CURRENT PERINATAL INFORMATION IN DIAL ACCESS LIBRARY. The Wisconsin Dial Access Tape Library is a source of immediate practical information for doctors and nurses providing perinatal care. Over 40 tapes are now available dealing with such problems as abruptio placenta, bacteremic shock, respiratory distress syndrome, hypoglycemia of the newborn, etc. Tapes are continually revised by the authors. This service is available to physicians for a $25 subscription fee. Nurses can utilize this service free of charge. For further information and a complete list of dial access tapes write: Dial Access Library, 610 North Walnut Street, Madison, Wis. 53706.

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20–21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

WISCONSIN PROFESSIONAL SOCIETY ON ADDICTIONS. Membership in the Wisconsin Professional Society on Addictions is open to those who are in a position of directing, administering or coordinating councils, information and referral centers, clinical settings for alcoholism or drug abuse or their divisions who have submitted a written application for membership. Membership fee is $10 annually. Applications should be sent to: William Roberts, 4200 Marquette Drive, Racine, membership chairman. John W. Sell is president of the society whose primary purpose is "to foster coordination, insure cohesiveness and upgrade effectiveness within the information–referral centers throughout the state."

INTERESTED SMS MEMBERS may obtain from the AMA a copy of a new, 185-page AMA paperback which consists of brief information on approximately 200 medical topics, plus references to AMA activities, policies and publications in each field. Send $1 per copy to AMA, 535 N. Dearborn St., Chicago, Ill. 60610. The reference book is available at 50¢ to medical students, interns, and residents. 4/73

ORDERS for Emeritus Dean William S. Middleton's new book, "Tangible and Intangible Values in Modern Medicine," are now being accepted by the Wisconsin Medical Alumni Association office. The 300-page book contains a collection of Doctor Middleton's 35 best non-clinical writings — articles and speeches that he has presented to medical and lay audiences over the past several decades. Cost: $11.50. Contact Mrs. Froland in the Medical Alumni office, 610 N. Walnut, Madison. Tel. 608/263–4914.

ALL PSYCHIATRISTS WHO HAVE not already taken the Psychiatric Knowledge and Skills Self-Assessment Program (PKSAP), are urged to apply for it by writing to the APA, 1700 18th Street, N.W., Washington, D.C. 20009. The test stresses patient management problems, allows participants to score themselves in relation to peers, and earns credits for continuing medical education. 4/73

FILMS

The Edge. The MEDIHC (Military Experience Directed Into Health Careers) Program has announced a new, 20 minute, 16mm color film entitled "The Edge." Filmed at hospitals and health facilities in Missouri, actual employers present their views on utilizing medically trained and experienced veterans in their facilities. It's available on loan, or Mr. Piernot, MEDIHC Coordinator, will present the film to you or to a gathering of your associates. Send inquiries to MEDIHC, Wisconsin Health Council, Inc., Box 1109, Madison, Wis. 53701.

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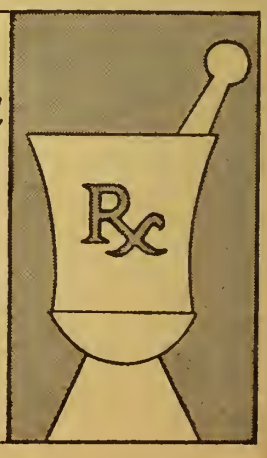

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

July 14–15: Council Meeting, State Medical Society of Wisconsin, Madison.

July 22–27: 1973—Summer Institute on Alcoholism, University of Wisconsin–Madison. Info: Richard Buckley, 610 Langdon St., Madison 53706.

July 23–27: Carthage Addiction Institute, Carthage College, Racine.

July 29–Aug. 3: Symposium on Alcoholism and Other Drug Abuse, Mt. Senario College, Ladysmith (endorsed by the Education Committee of the Wisconsin Academy of Family Physicians for 33 hours of postgraduate credit).

Sept. 8–9: Wisconsin Allergy Society meeting.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Sept. 14–15: Wisconsin Surgical Society Fall Meeting, Gateway Resort, Land O'Lakes.

Sept. 21–23: Wisconsin Radiological Society meeting, Sheraton Motor Inn, Madison.

Oct. 2–5: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison (tentative).

Oct. 6: Wisconsin Society of Pathologists meeting, Bellin Memorial Hospital, Green Bay.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

1973 NEIGHBORING STATES

July 14: North Central Regional Meeting of the American Association of Medical Clinics, sponsored by the Mayo Clinic and the Olmsted Medical and Surgical Group, P.A. of Rochester, Minn., at the Kayler Hotel, Rochester. Info: J. Minott Stickney, MD, Program Chairman, Mayo Clinic, 200 First Street, SW, Rochester, Minn. 55902.

Sept. 15–16: Seminar on "Management of Sexual and Marital Inadequacy," sponsored by the Institute for Comprehensive Medicine, at Chicago Sheraton Hotel, Chicago, Ill. (Same program will be held Sept. 19–20 at Regency Hotel, Atlanta, Ga., and Sept. 22–23 at Royal Sonesta Hotel, New Orleans, La.) Info: William S. Kroger, MD, 9735 Wilshire Blvd., Beverly Hills, CA 90212.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

Oct. 20–26: Annual Otolaryngologic Assembly of 1973, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

1973 OTHERS

July 16–20: Internal Medicine, U of Colorado School of Medicine, YMCA Conference Center, Estes Park, Colo.

July 26–28: Postgraduate Course on Biliary Tract Disease, American Gastroenterological Association, Playhouse, Aspen, Colo.

July 29–Aug. 1: Pediatrics, U of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Aug 2–4: Fifth Aspen Conference for Dermatologists, Rocky Mountain Dermatological Society and University of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Aug. 28–31: 70th Annual Meeting, Wyoming State Medical Society, at Jackson Lake Lodge in Grand Teton National Park, Wyoming.

Sept. 19–22: District V, American College of Ob–Gyn, Pantland Hotel, Grand Rapids, Mich.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Sept. 29: First Invitational Symposium on the Sero-Diagnosis of Cancer, cosponsored by the Laboratory Service, Naval Hospital, Bethesda, the College of American Pathologists (CAP), the American Society of Clinical Pathologists (ASCP), and the Armed Forces Radiobiology Research Institute (AFRRI), in the Naval Hospital Auditorium, National Naval Medical Center, Bethesda, Md. 20014.

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov. 8–10: Third National Conference of the Society for Computer Medicine, Denver, Colo. Info: Joseph M. Edelman, MD, President, Society for Computer Medicine, 200 Professional Center, 244 Peachtree Blvd., Baton Rouge, La. 70806.

Nov 29–Dec 1: National Conference on Virology and Immunology in Human Cancer, Waldorf–Astoria Hotel, New York, N. Y. Sponsored by American Cancer Society and National Cancer Institute.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Jan. 26–27: Council Meeting, State Medical Society of Wisconsin, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

1974 NEIGHBORING

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

MEDICAL MEETINGS . . .

1974 OTHERS

Jan. 2–5: Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, sponsored by the Division of Pediatric Nephrology, Department of Pediatrics, University of Miami School of Medicine, at Eden Roc Hotel, Miami Beach, Fla. Info: Div. of Continuing Education, UofM School of Medicine, P. O. Box 875 Biscayne Annex, Miami, Fla. 33152 (Tel. 305/350–6716).

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

Sept. 1–7: VII World Congress of Cardiology, Buenos Aires, Argentina. Info: American Heart Association, 44 East 23rd St., New York, NY 10010.

Oct. 21–25: Clinical Congress, American College of Surgeons, Miami Beach, Fla.

* * *

Symposium on Alcoholism and Other Drug Abuse is set for Sunday, July 29, through Friday, August 3, at Mt. Senario College in Ladysmith. Aimed particularly for the rural health and helping professionals. Endorsed by the Education Committee of the Wisconsin Academy of Family Physicians for 33 hours of postgraduate credit. Physicians or health professionals will be housed in one of the college dormitories or may stay at a nearby hotel–resort.

Among the speakers will be Dr. Joseph Benforado of Madison and Dr. Dan Anderson of Hazeldon Treatment Center, Center City, Minn.

Early registrations are being accepted. Correspondence should be directed to Dean Edwin Blackburn, Mt. Senario College, Ladysmith, Wisconsin. There is a $5.00 registration fee, plus $40.00 for the five-day workshop. Includes room and board and use of classroom facilities and equipment.

D. J. Flogstad, MD of Shell Lake is a member of the steering committee which is composed of representatives of Wisconsin and Minnesota state agencies and other educational and health-related institutions and organizations.

Third National Conference of the Society for Computer Medicine will be held in Denver, Colo., November 8–10. Should be of value to anyone interested in the use of computers for health care. Conference includes sessions on multiphasic testing, computer EKGs, on-line patient monitoring, laboratory systems, medical information systems, history systems, computer based medical records, and medical standards and automation. Info: Joseph M. Edelman, MD, President, Society for Computer Medicine, 200 Professional Center, 244 Peachtree Blvd., Baton Rouge, La. 70806.

Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management. Presented by: Division of Pediatric Nephrology, Department of Pediatrics, University of Miami School of Medicine, Miami, Florida. Director: Jose Strauss, MD, Professor and Chief, Division of Pediatric Nephrology. At Eden Roc Hotel, Miami Beach, Florida. On January 2–5, 1974. Tuition: $125; Residents and Fellows $50 with certification of Chief of Service.

A comprehensive review of major problems in Pediatric Nephrology. Pathogenesis, pathology, clinicopathological correlations, functional derangements and treatment of glomerulopathies, structural defects and infections, and chronic uremia will be emphasized.

Inquiries: Division of Continuing Education, University of Miami School of Medicine, P. O. Box 875 Biscayne Annex, Miami, Florida 33152 (Tel. A/C 305, 350–6716).

Institute for Comprehensive Medicine is sponsoring two-day seminars on "Management of Sexual and Marital Inadequacy" to be held September 15–16, Chicago Sheraton Hotel, Chicago; September 19–20, Regency Hotel, Atlanta; and September 22–23, Royal Sonesta Hotel, New Orleans, for physicians, psychologists, residents, interns and nurses. An interdisciplinary approach for the management of sexual dysfunctions will be discussed.

Topics covered will include: Psychology and Physiology of Sexual Response; Adolescent and Geriatric Sexual Problems; Behavior Modification; Biofeedback Control Therapy in Sexual Inadequacy; Compatible Divorce; Transsexualism; Sexual Variants and Fetishisms; Urologic Disorders; Management of Effective Orgasmic Response, and other subjects.

This continuing medical education course is acceptable for 20 credit hours in Category 2 for the Physician's Recognition Award of the American Medical Association.

For further information write: William S. Kroger, MD, 9735 Wilshire Boulevard, Beverly Hills, CA 90212.

First Invitational Symposium on the Sero-Diagnosis of Cancer, co-sponsored by the Laboratory Service, Naval Hospital, Bethesda, the College of American Pathologists (CAP), the American Society of Clinical Pathologists (ASCP), and the Armed Forces Radiobiology Research Institute (AFRRI), will be held Saturday, September 29, in the Naval Hospital Auditorium, National Naval Medical Center, Bethesda, Md. 20014.

Objectives: To provide a forum for disseminating information on the current status of the sero-diagnosis of cancer, to allow interested investigators to present the results of their investigations and to share information on techniques and methodologies. To acquaint clinicians with the availability, usefulness and limitations of these techniques. To publish the formal presentations for inclusion in the medical literature. To provide an opportunity for holding wet workshops in diagnostic techniques and methodologies.

Wet workshops in methodology under the auspices of the ASCP will also be offered the day preceding or following the symposium in the Student Laboratory spaces at the Naval Medical Training Institute. The Symposium papers will be divided into three major categories: (1) Enzymes in the Sero-Diagnosis of Cancer, (2) Unique Antigenic Systems in the Sero-Diagnosis of Cancer, and (3) Glyco-Protein Correlations in the Sero-Diagnosis of Cancer.

The proceeding will be subsequently published as a special report under the auspices of the Armed Forces Radiobiological Research Institute (AFRRI) and made available through the Government Printing Office.

A registration fee of $40.00 will include attendance at the symposium, parking, noontime luncheon, and a copy of the proceedings. Advanced registration is required.

For further information, including a copy of the complete program, information on nearby hotels and workshops, write: Symposium, College of American Pathologists, 1775 K Street, NW, Washington, D.C. 20006 (Tel. 202/466–2121).

VII World Congress of Cardiology will be held from Sept. 1 through 7, 1974 in Buenos Aires, Argentina. This meeting which is held every four years, brings together scientists from all parts of the world for a week of intensive exchange of information on advances in the cardiovascular diseases.

For convenience and economy the American Heart Association, Congress sponsor, has designated Thomas McGuire Enterprises as the official travel coordinators for its members. The 17-day South American tour includes visits to Brazil and Peru as well as Argentina. Info: TME, 605 East Algonquin Road, Arlington Heights, IL 60005.

North Central Regional Meeting of the American Association of Medical Clinics, July 14 at the Kayler Hotel, Rochester, Minn. Sponsored by the Mayo Clinic and the Olmsted Medical and Surgical Group, P.A. of Rochester.

The session, covering various phases of the group practice of medicine, will be open to all group practice physicians and administrators in the Region. The North Central Region of the AAMC is represented by the states of N. Dakota, S. Dakota, Nebraska, Minnesota, Iowa, Wisconsin, Michigan, Illinois, and Indiana.

Keynote speaker of the conference will be Dr. William Hildebrand of the Riverside Clinic, Menasha, Wis. As Chairman of the Council of Medical Service of the AMA, Dr. Hildebrand will discuss the current status of PSROs. Individual presentations will follow on the topics of Auditing Clinic Records and Accrediting Medical Groups.

Further info: J. Minott Stickney, MD, Program Chairman, Mayo Clinic, 200 First St., SW, Rochester, Minn. 55902.

Course in Laryngology and Bronchoesophagology. The Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, will conduct a continuing education course in Laryngology and Bronchoesophagology November 12 to 17, 1973. Course is limited to 20 physicians.

It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diag-

nostic and surgical clinics, as well as didactic lectures.

Interested physicians write directly to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, Ill. 60612.

Annual Clinical Congress, October 15–19, Chicago. Official headquarters will be the Conrad Hilton Hotel, with sessions at McCormick Place and several area hotels.

The program will include:

- 16 *postgraduate courses* (accredited by the Council on Medical Education of the American Medical Association).
- More than 250 research-in-progress reports, called the *Forum on Fundamental Surgical Problems.*
- Some 89 *panel discussions and symposia* in general surgery and the surgical specialties.
- *Correlative Clinic,* case studies showing the value of close cooperation between general surgery and the surgical disciplines.
- *Operative telecasts* from Loyola University Hospital, Maywood, Ill.
- More than 90 *films and Cine Clinics* including those in "spectacular" surgery.
- *Special sessions* in cancer, trauma, surgical education, operating room environment and international relations.
- *"What's New In Surgery"* resume.
- Approximately 400 *scientific and industrial exhibits.*

INFORMATION ON FEES: Fellows of the College whose dues are paid to Dec. 1972 may register free. Initiates, members of the Candidate Group and surgical residents register free. Non-Fellows pay $90, non-Fellow doctors in the Federal Services pay $50. *Everyone* taking one of the 16 postgraduate courses must pay the fee for the course selected.

A pre-Clinical Congress *Scientific Communication Workshop* will be held Oct. 13 and 14. (*Separate* $100 fee, which includes two luncheons. Special registration form available from Publications Department.)

The Clinical Congress of the American College of Surgeons is open to all doctors of medicine. Official forms for registration, housing and postgraduate courses available after June 1. Contact: Fred Spillman, Convention Manager, American College of Surgeons, 55 E. Erie Street, Chicago, Ill. 60611, phone (312) 664–4050.

Annual Otolaryngologic Assembly of 1973 will be held October 20 through 26, 1973, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology of the Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists. Designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to the mailing address: OTOLARYNGOLOGY, P. O. Box 6998, Chicago, Ill. 60680.

A separate, but correlated course, **"Conference on Radiology in Otolaryngology and Ophthalmology"** will be held on Friday and Saturday, November 23 and 24. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, Abraham Lincoln School of Medicine, P. O. Box 6998, Chicago, Ill. 60680. □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

Headaches: The Kinds and the Cures. By Arthur S. Freese, DDS. Doubleday & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 182 pages. Price: $6.95

Your Prostate. By Robert L. Rowan, MD and Paul Gillette, PhD. Doubleday & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 147 pages. Price: $5.95

Handbook of Pediatrics. By Henry K. Silver, MD, C. Henry Kempe, MD & Henry B. Bruyn, MD. Lange Medical Publications, Los Altos, California. 1973. 693 pages. Price: $6.50

Thyroid Tumours, Lymphomas, Granulocytic Leukemia. M. Fiorentino, R. Vangelista, E. Grigoletto, Editors. Proceedings of the II Padua Seminar on Clinical Oncology, Padua, Oct. 1972. Piccin Medical Books, Via Porciglia, 10 35100 Padua—Italy

Polymerization in Biological Systems. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corporation, Summit, New Jersey 07901. American Elsevier Publishing Company, Inc., 52 Vanderbilt Ave., New York, N.Y. 10017. 1972. 314 pages

Physiology, Emotion and Psychosomatic Illness. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corporation, Summit, N.J. 07901. American Elsevier Publishing Company, Inc., 52 Vanderbilt Ave., New York, N.Y. 10017. 1972. 421 pages

Healthful Living. Ninth Revised Edition. By Harold S. Diehl, MD and Willard Dalrymple, MD. McGraw–Hill Book Company, 1221 Avenue of the Americas, New York, N.Y. 10020. 1973. 465 pages. Price: $12.95

Newer Anticancer Drugs and Procedures. M. Fiorentino, Editor. Proceedings of a Clinical Oncology Seminar, Padua, Sept. 1971. Piccin Medical Books, Via Porciglia, 10 35100 Padua—Italy

We Mainline Dreams—The Odyssey House Story. By Judianne Densen–Gerber, MD. Doubleday & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 421 pages. Price: $9.95

Protein Turnover. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corporation, Summit, N.J. 07901. American Elsevier Publishing Company, Inc., 52 Vanderbilt Ave., New York, N.Y. 10017. 1973. 319 pages

Intrauterine Infections. Ciba Pharmaceutical Co., Division of CIBA–GEIGY Corporation, Summit, N.J. 07901. American Elsevier Publishing Company, Inc., 52 Vanderbilt Ave., New York, N.Y. 10017. 1973. 219 pages

Handy Home Medical Adviser and Concise Medical Encyclopedia. By Morris Fishbein, MD. Doubleday & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 410 pages. Price: $5.95

BOOK REVIEWS

Proceedings of the International Conference of Nosocomial Infections

American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill. 60611. 1971. 334 pages. Price: $1.50

There has been an increasing awareness and mounting concern over the incidence of nosocomial infections on the hospital scene. The International Conference on Nosocomial Infections which was held at the Center for Disease Control in Atlanta, Ga., in August 1971 addressed itself directly to this problem. The resulting "pool" of information gathered included such matters as:

1. National trends and patterns which were presented by several nations.
2. The microbial agents involved, their source or reservoirs and means by which they are transmitted.
3. Factors contributing or predisposing patients to infections.
4. Systems for initiating controls such as Infection Committees and surveillance teams.
5. The control of microbial contamination in patient-care equipment, medications, and in the hospital environment.

This publication offers a wealth of information directed mainly towards the control of nosocomial infections. It is highly recommended reading for all hospital personnel especially those who may be involved in infection control programs.—HAROLD SAFAFIN, MS

Urinary Tract Infection and its Management.

Edited by Donald Kaye. 1972. The C. V. Mosby Co., St. Louis, Mo. 290 pages. Price: $22.50

Thirteen contributors to this book each have written a chapter on urinary tract infections in their particular field of expertise. A detailed review is given of the etiology, pathogenesis treatment and prognosis of urinary tract infections in children as well as adults. A sys-

CONTRIBUTIONS—CES FOUNDATION
April 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1973:

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Woman's Auxiliary to the Sheboygan County Medical Society
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BOOKSHELF . . .

tematic evaluation schedule of patients with urinary tract infections is given starting with the diagnosis by urine culture, radiological examination and renal function testing in patients with urinary tract infections.

A good chapter is written on the prevention of urinary tract infection in patients with indwelling catheters and a review is also given of the use of various antibiotics in chemotherapeutic agents in the treatment of urinary tract infections.

There is surprisingly little overlap among the various chapters considering the many independent contributors to this book. There are very few clear mistakes in the book. It must have been an oversight by the editor when he recommends urea and diodrast clearances as expressions of glomerular filtration rate in the chapter on renal function.

This book was originally meant as a text for medical students but will also serve well as a reference text for every practicing physician who is involved in the treatment of urinary tract infections. The text is straightforward and clear and covers most areas and problems in the diagnosis and treatment of urinary tract infections.—PAUL O. MADSEN, MD

Cardiovascular Physiology

By Robert M. Berne, MD and Matthew N. Nevy, MD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1972. 265 pages. Price: $9.25.

A good review of basic Cardiovascular Physiology. The book was designed for use as a basic textbook with little direct correlation to cardiovascular disease. The figures are simple but nicely illustrate the basic points.—J. E. KENDRICK, PHD □

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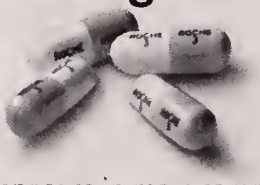

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholog dependence have not been reported o recommended doses, use caution in ad ministering to addiction-prone individ or those who might increase dosage.

Precautions: In elderly and debilitated initial dosage should be limited to 15 m to preclude oversedation, dizziness ar or ataxia. If combined with other drug having hypnotic or CNS-depressant effects, consider potential additive effe Employ usual precautions in patients who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

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depression or suicidal tendencies. dic blood counts and liver and kidunction tests are advised during ted therapy. Observe usual precauin presence of impaired renal or ic function.

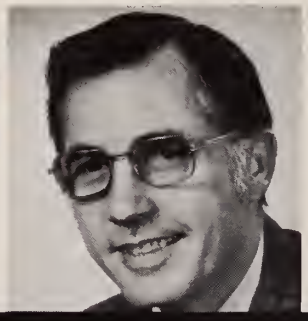
rse Reactions: Dizziness, drowsilightheadedness, staggering, ataxia alling have occurred, particularly erly or debilitated patients. Severe ion, lethargy, disorientation and , probably indicative of drug intoler- or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"



Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by forn AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated ir crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients . . .

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econor c impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inter ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmaci made in the absence of clinical kno edge of the patient, could expose hi to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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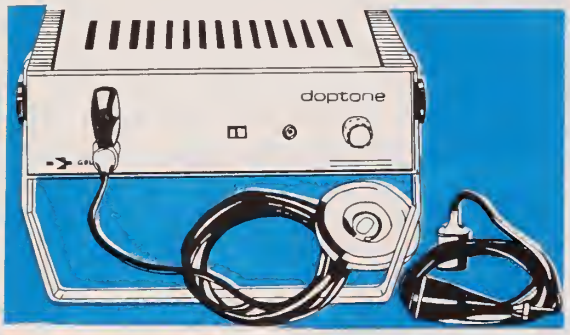

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Editorials

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Raymond Headlee MD Elm Grove

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Misperceptions

IN THIS THIRD of a series of editorials* about the current flutter concerning peer review, the broad subject of misperceptions will be examined, hopefully without too many misperceptions of my content, or of my intent.

For the most part misconceptions based on differences in life style, or systems of thinking, can bring trouble whenever we think about the coming peer-review blanket which is settling over the practice of medicine. At the purely personal level, who has not shuddered, when reading some of the massive writing about peer review, at the secret thought: "Well if I have to be examined by Dr. ———— whose work and standards I disrespect, I'd rather drive a cab."

Now in the privacy of our minds we use stronger terms than disrespect, and we flash like lightning to this case or that hospital episode, or the time he made a fool of us. Even the least paranoid of us can easily believe that our deepest personal enemy (defined: practices far differently than we do) could just manage to slip into the peer-review committee. Can't you hear his sonorous tone as he examines the blank spaces in our latest stack of charts, and who cannot hear his sly laugh to the other Kafka-like physicians up there on the panel examining us? These differences are real, and while most physicians are intelligent enough to focus on flaws if they are so inclined, most I have known simply do not need to do so.

It is no mere accident that the ability to accept even serious differences increases with each year of practice. Fortunately it is usually the older doctors who serve on such panels, but of course not always. One short example shows what can happen. A social worker who had come to me for treatment decided, after several years of what we both considered successful therapy, to enter private practice. She asked me about several physicians with whom she might go into practice. My suspicions were

*The first editorial (May) dealt with the struggle to say anything at all critical of our peers. The second (June) dealt with fundamental difference in medical thinking, at the technical level.

lulled by the personal pleasure in having worked with her, so I spoke of my dissatisfaction with professional standards on one albeit formally well trained physician. Three days later I received a vile letter from this fellow's attorney threatening me with suit if I did not desist from slanderous remarks.

There is much written about patients trusting doctors. Nothing is said about our trusting patients, or at least trusting our judgment as to their misperceptions. If so mild a comment under these highly protective circumstances could cause this explosion, what could happen when we have actual power over the other person's license, hospital privileges, and the like! Concern is justified.

A second area of misperception comes regarding what we believe our charge to be within the practice of medicine. Not long ago I received an irate letter from a physician in another state who had read one of my editorials about peer review. He chided me for nit-picking such small differences as professional skills or approaches to medical tasks. He was intent that now at least we had an effective tool, peer review, against the troupes of physicians that sign "sick slips" for their patients on days before and after weekends, shutdowns, and strikes in the industrial plant where he was plant physician. These, he said, are the real ones we should go after and the sooner the better. He did not seem concerned with the doctor-patient relationship among the workers and their family doctors, nor their working conditions, nor the nature of their perceptions of their relationship with the plant, nor with him. This relatively simple example shows something of the vast wonderland of misperceptions about what we are in medicine to do.

Peer review can serve lofty, as well as base, motivations. But it is often hard to tell which is which. The current controversy over an individual's right to his own body, whether we agree with him, is a further example. Thus the right to die, the right to alter parts of our bodies, especially if we be female, and the right to think as we wish or more especially to live as it suits us rather than be involuntarily hospitalized, are all at issue and all go beyond the purely medical judgment, far into moral, social, and psychological judgments.

Of course in psychiatry, if that specialty exists at all as a consistent discipline, misperceptions can multiply over and over. Recently in this state the right of the State, relegated to the hospital psychiatrist, to hospitalize someone against his will has been seriously limited. The power exists if cause can be shown of danger to others, or to self, yet the measurement of control over impulses is perhaps one of the most difficult judgments we are required to make. But this one is easy compared to the exploding feelings over psychosomatic conditions, or over the more subtle defects in living and loving.

Is it malpractice to give sedative drugs or shock treatment to a person, thereby depriving him of any chance to think through his problems, or to learn new coping methods? Or, is it malpractice to talk to him about these flaws rather than immediately rushing him into physical and chemical seclusion to prevent harm to himself and to prevent anxiety in the family? During World War II, which a decreasing number of us remember, this was put to severe test when the then Secretary of the Navy jumped to his death from the Bethesda Naval Hospital's seventh floor. A friend of mine, George Raines, was then Chief of Psychiatry at that hospital, and it fell to him to deal with the board of admirals who investigated why the Secretary was not better "protected." But how many preconceptions must he have encountered while holding to his salient principle of calculated risk? Dramatic as this example is, it occurs every time a surgeon operates, or does not operate. It occurs every time a pathologist diagnoses a section as malignant, as doubtful, or as something else. It occurs in almost every office visit when a physician decides to hospitalize for any of many reasons.

And so it goes. If we believe peer review will solve these problems, we will be sorely disappointed. A rigid system of peer suppression might drive away all who think not like us. Why not rather allow for some differences in perception and alter our judgments of our peers according to factors other than their different ways?—RH

Conundrum

EVERY MONTH WHAT numbers 50, weighs 30 pounds (13.6 Kg), and adds up to a total of over 6,000 pages? It is the mass of medical publications received by one physician! Mine may be a conservative figure, as a more scientific study by an 18-man clinic in Green Bay reported a monthly tared total of 1300 pounds (600 Kg).

This deluge of printed material, although it represents a fine contribution to the Girl Scout paper drive in the interest of ecology and recycling, is enough to boggle the mind of even a speed-reading physician. If one were to forego seeing patients and/or eschew the attendant mountain of paper work, it might be possible to plow through this monthly mound.

Most of these journals, euphemistically called "controlled circulation," are more commonly called "throwaways." The cost of advertising in these sleek, colorful productions is fantastic, and reported to be 80% of the $100 million annual pharmaceutical advertising budget.

The number of journals continues to increase. Four new ones appeared in April, and in June came Vol. 1, No. 1 of *Sportsmedicine*. Impressive was its three page ad for a birth control pill. *Medicine* no doubt, but *Sports* would be a stretch of sematics except for an old colloquialism. Even the AMA had to get into the act with its bright new *Prism*. Four publications are slanted toward our recreation, diversion, and relaxation. Another six specialize in financial and socio-economic advice, and four are in the medico-legal field.

If you are inclined to do something (other than circular filing) about this wasteful incursion upon your already limited time, there are measures to take. First, discuss the situation with the pharmaceutical representatives who call on you. You might suggest that their advertising budgeteers give greater consideration to publications such as the *Wisconsin Medical Journal*—and much less to the throwaways. Second, hand some of the excess journals back to the postman indicating your refusal to accept them. Postal regulations require that the publisher be notified—at a small cost to the publisher. This might be sufficient to get your name off the mailing list, especially if it is repeated *p.r.n.*

Perhaps the anticipated paper shortage may cause some atrophy of the hypertrophied publications—or the overgrowth might result in strangulation. Either situation would improve the survival rate of purely scientific and state medical journals. But today there arrived a tape called an audio-journal! —VSF

No Rose Without a Thorn

In our increasingly specialized world of medicine we are witnessing many new techniques for diagnosis and treatment. For the most part such techniques are valuable and safe. But with any incursion into the human body, whether by mechanical devices, chemical substances or psychic manipulation, the alert physician feels it is his responsibility to know ahead of time, if at all possible, what side effects can mar an otherwise useful medical event. Certainly he must recognize such side effects when they occur and learn how to cope with them. Howard Mauthe, in this issue, has contributed to our knowledge about prevention, and correction when prevention is not possible, of catheter emboli which are used increasingly in our hospitals.

Your attention is invited to this excellent and helpful presentation.—RH □

MEDICAL COMMENT FROM OTHER PUBLICATIONS

IV Fluids

Despite the vigor and sense of urgency displayed by the FDA in removing and controlling many essentially harmless drugs over the past 7 years, the agency has failed miserably in certain areas which should have received primary attention. One of these is in the area of quality and standards for medical and paramedical products. Ironically, the agency has imposed rigid controls on containers and the apparatus employed in administering intravenous fluids while largely neglecting the piece de resistance, ie, the fluids themselves.

Over a five-year period, 9,122 of 81,045 bottles of intravenous fluid inspected in a single hospital were found to be contaminated with particulate matter visible to the naked eye; bacterial contamination was present in some bottles. (*New England Journal of Medicine,* Nov. 30, 1972, p 1152)

The need for improved standards in intravenous fluids is obvious. Until such time as the FDA condescends to impose and enforce such standards, all hospitals should maintain an intravenous fluid inspection program. This involves careful inspection of all fluids against a light and dark background prior to administration; accomplished routinely by trained technicians, the screening procedure is well worth the time and effort involved.—Reprinted from NOTES AND TIPS, Harper & Row Publishers, Inc., Hagerstown, Md., vol. 3, no. 9, March 1973 □

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Physician Distribution Semantics

TO: THE MEDICAL EDITOR—There are a myriad of reasons for not accepting Dr. Korst's commentary, ["Manpower by Specialty in Wisconsin," *Wisconsin Medical Journal,* April 1973] but all fall into two general categories, methodology and conclusions. First, methodology. The article by Mason upon which Dr. Korst bases his own study has been severely criticized because of its methodological shortcomings. After Mason's article appeared, *JAMA* published a sharp response (Dec. 11, 1972) from a researcher in the AMA Center for Health Services Research and Development, who scored Mason for attempting to simplify the complex issue of physician distribution, both geographic and within specialties.

It is no surprise, then, that Dr. Korst, by adopting Mason's model, also oversimplified the complex issue of physician distribution. For Wisconsin Korst fails because he uses "optimum" physician-to-population ratios for too large a geographical area [the administrative district] to be meaningful. Dr. Korst's use of "optimum" physician ratios by administrative district, in addition to his attempted correlation with average ratios by specialty for six prepaid group practices in highly urbanized population practice settings, combine to fail in distinguishing between physician imbalances in rural, urban, and inner city environments in Wisconsin. It is only at the level of the county and community (or medical service area), we believe, that physician-to-population ratios become meaningful.

Dr. Korst's faulty methodology could only lead to equally faulty conclusions. He suggests, for instance, that Wisconsin's physician manpower problems might be cured by increasing the numbers of pediatricians, internists, and OB-gynecologists in training. Once trained, however—and this is a crucial point since Korst expresses concern with physician distribution (p. 107)—Korst fails to theorize how these newly trained specialists might be convinced to distribute themselves more equitably across the state.

We know already that distribution of these specialists is very poor. As of 1970, only 37 out of the state's 72 counties had internists, 21 out of 72 contained pediatricians, and only 25 counties had OB men. If part of our mission is to improve the distribution of physicians across the state and provide better medical care at the point of entry into the delivery system, it is an illusion that just *training* more pediatricians, internists, and OB men would do the job.

While internists, pediatricians, and OB-gynecologists may or may not constitute a proper physician "mix" in a large prepaid group such as HIP or Kaiser-Permanente, the primary care needs of *Wisconsin* citizens will not be met by training more of these specialists without a workable formula for keeping the physicians in the state and distributing them more equitably. More fundamental is the question of how to train and distribute pediatricians, internists, and OB men who will remain generalists within their specialties rather than becoming "superspecialists" who no longer deliver primary care.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

While it is true that "data related to specialty training and distribution provide parameters for future planning for physician training programs in Wisconsin," Dr. Korst's statistics indicate no need for training Family Physicians because the number of Family Practitioners in Wisconsin is "fairly close to the national averages and considerably better in physician-to-population ratio than the experience in the six large practice groups." (p. 110) That there is no need to train Family Physicians in Wisconsin must be an incredible revelation to state citizens, practicing physicians of all specialties, enlightened medical educators, legislators, and, most importantly, patients. Researchers in the academic center should also be startled because to help reach that conclusion, Dr. Korst included DOs under "Family Practice" when he compared Wisconsin Family Physician numbers to national averages which did *not* include DOs!

If Dr. Korst's intention was to stimulate controversy over physician manpower requirements in Wisconsin, he has succeeded admirably.

John H. Renner, MD
Director
Dale E. Treleven, MA
Research Director
Family Practice Program
Madison

TO: The Medical Editor—I would like to thank the editors of the "Journal" for allowing me to respond to Dr. Renner and Mr. Treleven. I am pleased that the publishing of statistics dealing with health manpower has stimulated some controversy. There is a need to base planning in the health care field on firm data and experience of successful health care plans in other parts of the country. The medical center has the responsibility of designing and planning training programs to meet the needs of the community; the legislature is assuming more responsibility for financing such programs; and the ultimate success of any plan is determined by the consumer.

I find it difficult to accept the fact that we have a complete health care crisis in the State of Wisconsin. To be sure there is need for improvement, but, as I have watched the remarkable growth of excellence in medical care at such centers around the state as LaCrosse, EauClaire, Marshfield, Wausau, and Sheboygan to name but a few, it would appear to me that the model developing in Wisconsin needs only to be further improved by a careful look at distribution and how one supports these clinics through cooperating physicians in affiliated clinics in smaller communities. The primary care necessary may well be rendered by family practice physicians as well as those trained in medicine, pediatrics, obstetrics, etc.

One has to look carefully at the medical environment attractive to young physicians. It appears to me that new physicians seek above all other goals; satisfaction from intellectual achievement. They demand, during seven years of training as medical students, interns, and residents, a high quality training in-depth in order to feel confident and mature for practice in the community. Most new physicians today seek location in multi-specialty groups, and family practice groups oriented towards primary patient care where there is a plan for a balanced practice, equitable income, retirement, time for family, and a program for continuing education. Patients seek medical groups in centers for treatment of major illness but will accept a different level of continuing care as long as there is visable continuity between the medical center and the community clinic. They prefer personal identification with their physicians.

There is some demand for an increased number of physicians although it may be only a few years before we catch up with this need. The management of the health care region and the distribution of the physicians and care within the region appear to be the major need. I would doubt that the medical needs of any group of people vary greatly from the patient populations presently served by large prepaid practice groups. Primary medical care is a responsibility of all physicians regardless of their specialty training. Answers to the major issues of health care confronting us now will come from study of available data and experimental models to test physician and consumer acceptance. It is a matter of planning and cooperation to provide the current excellence in medical care to all citizens of the state.

Donald R. Korst, MD
Professor of Medicine
Director
Independent Study Program □

HOW THE
State Medical Society of Wisconsin
SERVES

The State Medical Society of Wisconsin belongs to its members: the physicians of Wisconsin. It is theirs to direct, to use, and to serve. To benefit fully from membership in the State Medical Society, the physician should take advantage of the many services the Society offers.

This is the last in a series of articles explaining State Medical Society organization and activities.

Society Has Major Role In Health Care Payment Programs

SOCIAL AND HEALTH LEGISLATION has long been a concern of the State Medical Society. One of the early recorded efforts of the Society in this direction is an action by the House of Delegates in 1916 to establish a special committee to study social insurance and keep the profession as fully informed as possible on the subject. Since that time, the Society has come to play an important role in a number of programs which provide payment for medical care.

WPS Blue Shield

In 1946 the House of Delegates of the State Medical Society established WPS (Wisconsin Physicians Service) Blue Shield to provide basic protection against the costs of medical and surgical care on a nonprofit basis. WPS is an active member of the National Association of Blue Shield Plans (also established in 1946) and cooperates in the administration of national and local Blue Shield plans and programs.

The Commission on Medical Care Plans, created by the Council of the State Medical Society on November 17, 1951, implements the policies and administration of WPS. The Commission, composed of physician members of the Society as well as selected nonmedical members, is directly responsible to the Society's Council (board of directors).

WPS has been one of the most innovative Blue Shield plans in the country. In 1954 it originated the idea of paying the physician's "customary, usual and reasonable fee." This concept, which became the byword among Blue Shield plans, did away with fee schedules and income limitations. Instead, WPS paid the physician his "reasonable charges" for services covered by the WPS contract. If there was any question as to what was "reasonable," it was settled by the county medical society.

In 1958 WPS also became one of the first Blue Shield Plans in the nation to make available a special policy for senior citizens. Called the "Century Plan," the policy was offered only to persons over 65 years of age with no upper age limit. With the coming of Medicare in 1966, WPS offered the most comprehensive supplementary health insurance of any Blue Shield plan in the nation.

The most recent innovation by WPS is its health maintenance plan (HMP). For a monthly premium, part of which goes directly to the physician, the subscriber can draw on a wide variety of medical services including routine doctor's office calls with little or no additional cost. In cases where the

To answer questions about any subscriber's coverage, WPS claims adjusters can simply push a button on this machine. It is hooked into the computer and flashes the answer on the screen just two seconds after the proper button is pushed. In background is Bill Schweers, WPS claims manager.

services of a specialist are indicated, such as a neurosurgeon, the insurance pays this individual on a fee-for-service basis. The experimental plan is an effort to encourage early and preventive treatment while preserving the traditional doctor–patient relationship.

The headquarters for WPS activities is the State Medical Society's building in Madison. Some 375 WPS employees work to provide insurance protection for surgical, medical, hospital, and related health-care services to nearly a half million persons in Wisconsin. Among these are members of the Federal Employees Program, for which WPS Blue Shield is a Wisconsin carrier. During 1972 all types of Blue Shield contracts provided payments of over $43,937,000 to Wisconsin providers for their services to patients.

Medicaid

Medicaid (Title XIX) is part of Social Security and has been available to Wisconsin residents since July 1, 1966. Through a contract with the State Department of Health and Social Services, WPS provides a system of payment to those giving service to Medicaid patients.

Some 86 employees service this contract, which includes all of Wisconsin, except Milwaukee County. The eligibility of the individuals who apply for medical assistance is handled through each county welfare department.

Medicare

Medicare (Title XVIII–Part B) is also part of Social Security available since July 1, 1966, to all Americans over 65 years of age. WPS is a carrier for Part B benefits (medical insurance portion) for the State of Wisconsin excluding Milwaukee County. Over 100 employees of WPS service the approximately 350,000 eligible beneficiaries.

CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is the federal government program providing benefits to cover part of the cost of medical care for the dependents of active duty servicemen and for personnel retired from the services and their dependents. The program was first established in 1956. Through a WPS contract, eight employees handle the medical portion of the CHAMPUS program in Wisconsin. □

STATE MEDICAL SOCIETY OF WISCONSIN

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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SECTION OPHTHALMOLOGY

JULY 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

INSURANCE COMMITTEE REPORT

The Insurance Committee of the Section on Ophthalmology met in Milwaukee May 16 and in Madison May 21. Those present at the Milwaukee meeting were: MDs Samuel S. Blankstein (chairman), Donald E. Chisholm, Herbert R. Giller, Milwaukee; Jerome G. Kadell, Elmer E. Johnson, James C. Allen, Madison; and Mr. H. B. Maroney, assistant secretary of the State Medical Society of Wisconsin. Those present at the Madison meeting were: MDs Blankstein, Johnson, Allen and Kadell, and Mr. Maroney. Also present at the latter meeting were Mr. Ray E. Koenig, executive director of Wisconsin Physicians Service (WPS-Blue Shield), and Mr. Roger H. Graham, director of research and planning of WPS.

Wisconsin Physicians Service has been selling prepaid eye care insurance since about November 1972. This prepaid eye care insurance reimburses both ophthalmologists and optometrists for reasonable and customary fees plus eye glasses. Since this plan is relatively new, no cost figures are yet available.

Some ophthalmologists have objected to WPS selling insurance to both ophthalmologists and optometrists in the same plan, with a choice of either, because some patients mistakenly equate the services rendered by ophthalmologists and optometrists as being equal. Mr. Koenig pointed out that WPS offers this plan because it has to compete with other insurance companies who offer similar coverage to large companies and unions in order to secure the whole medical contract. Both Mr. Koenig and Mr. Graham said that WPS could discontinue this type of coverage, although they felt certain that other competitors would fill the void.

The optometric association has its own prepaid eye care insurance plan which it sells to large industrial companies and unions. The optometrists' plan pays a fixed amount to an optometrist or ophthalmologist while WPS pays reasonable and customary fees to both optometrists and ophthalmologists.

The second problem discussed by the Insurance Committee concerned the possibility of establishing a foundation to sell prepaid eye care insurance for only ophthalmologists. Ophthalmologists in Colorado have formed such an organization. The WPS representatives pointed out that the reason for the success of the Colorado ophthalmologists' prepaid eye care insurance company foundation was because the optometrists' association had an insurance plan that did not include ophthalmologists and the local insurance companies were not providing insurance to both optometrists and ophthalmologists such as WPS does here in Wisconsin. Therefore, the ophthalmologists in Colorado created an insurance company to fill this void.

The Insurance Committee plans further discussions with WPS-Blue Shield, Surgical Care-Blue Shield, and Blue Cross.

An ophthalmologist having any thoughts on prepaid eye care insurance is urged to contact Samuel S. Blankstein, MD, 2040 West Wisconsin Ave., Milwaukee, Wis. 53233.

DATES TO REMEMBER

Oct. 6-7: Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology Fall Meeting, Downtowner Motel, Green Bay. Inquiries to: John Ottum, MD, Green Bay, President. □

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

SPECIAL

LaFayette County Heart Risk Screening Program

DAVID F. RUF, MD
Darlington, Wisconsin

PRIMARY MEDICINE in a rural setting becomes increasingly challenging as advances in medicine are perceived and attempts are made to bring the benefits of progress to rural communities. LaFayette County is a typical rural model, having a central "county seat" where the hospital is located and at least six surrounding small communities which maintain their own small school systems. Traditional rivalries and clannishness are thus innocently perpetuated and people are usually reluctant to leave their community to participate in "something new." Organizations such as homemakers, parent–teacher organizations, and church groups are viable within the smaller communities and are often utilized by national fund-raising organizations such as Cancer, Heart, and the like.

The industrial base of the county is dairy–hog agriculture and many farmers are members of the National Farmers Organization and Farm Bureau. To involve such people in a "heart-risk" screening program involves the breaking down of animosities engendered by uninformed but dedicated spokesmen of the organizations of agriculture. Indeed a number of successful agriculturalists in LaFayette County have in the past made strong statements about the threat to their products posed by the American Heart Association.

Reprint requests to: David F. Ruf, MD, 517 Park Place, Darlington, Wis. 53530.

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In an effort to involve farmers in the program, the time of year was considered, with November being selected as the month when most field work would generally be completed. The time of day that seemed best was the morning hours immediately after morning milking chores.

These considerations, and the knowledge that hypertension, obesity, and arteriosclerosis are major health problems in the area, led to the formulation of what may be a rural model for "heart-risk" screening. To involve reluctant people in such a program, it was felt that genuine community participation would have to be achieved. Equally important was the timing of the program with farmers' schedules so that fasting specimens for cholesterol and triglycerides could be drawn without subjecting the participants to inconvenience and prolonged hunger pangs. Accordingly, local homemaker and heart organizations were contacted in five communities of the county. Local publicity campaigns were intensive, using traditional media as well as frequently more successful rural methods, such as church bulletin inserts and grocery bag stuffers. The "clinics" were scheduled from 8:00 to 10:00 a.m. with assurances that people who arrived early or late also would be accommodated.

Prior to implementation, a number of in-depth planning sessions were held with representatives of the Wisconsin Heart Association, State Nutritionists, State Public Health Department officials, and others. Out of these meetings emerged a credible definition of purpose for "heart-risk" screening. It was decided that case finding would be the most dramatic result of the initial program, but it was agreed that preventive medicine through education and follow-up would greatly outweigh the immediate benefits of simple case finding.

I. Method

All persons 18 to 65 years old were eligible and there were no charges.

II. Location

Each clinic was held in a community center building familiar to the people of that community.

III. Staff

(a) Registration and history-taking volunteers were local people. They were friendly faces familiar to participants.

(b) Weights and blood pressures were recorded by trained persons residing in the individual communities.

(c) Venapunctures for cholesterol and triglycerides were done by skilled technicians. Where possible, these people were also from the community where the clinic was being held.

(d) Refreshments were provided by local merchants and organizations. Informational materials were available at the refreshment table. Opportunity was provided for conversation with the physician and nurses in attendance.

(e) LaFayette County Community Health Nurses were direct supervisors of each clinic.

(f) An MD from the County Medical Society was present at each clinic. His main purpose was to answer questions of participants.

IV. Forms

An example of the form used is shown (Fig 1). More detailed forms were considered but were not used because of time-yield considerations and the lack of sophisticated staff. One copy was mailed to the personal physician of each applicant and the other was filed at the LaFayette County Community Health Nursing Service Office.

V. Follow-up

Each participant received notice that he: (1) had no significant "heart-risk" factors, or (2)

had significant "heart-risk" factors and should consult his physician to discuss the problem with him.

Results

Over 800 participants were served in six 2-hour sessions held in five different communities of LaFayette County. Forms with findings were individually screened by county medical society members and community health nursing service nurses. Forty to 50 percent of participants were advised to consult their personal physicians about significant "heart-risk" factors.

Criteria for referral were: (1) Two or more factors were significantly elevated; *eg,* an obese smoker whose other factors were normal would get a referral letter. (2) Marked elevation of one definitely related factor; *eg,* a very high cholesterol alone would result in referral; a very high blood pressure alone would result in referral. (3) Age consideration; *eg,* a 64-year-old person with known positive family history and moderate hypertension would probably not be referred; a 30-year-old person with the same findings would get a referral letter; knowing the individual was often valuable in making borderline decisions; where doubt existed, a referral letter was sent.

Post-screening Activities

A series of sessions on diet, exercise, smoking, and the like was planned and implemented. Participation was poor. Factors influencing poor participation were: (1) publicity failures, (2) lack of physician enthusiasm in individual patient direction, (3) adverse weather, (4) time and location (meetings were held only in Darlington), and (5) apathy and inertia coupled with usual rationalizations about other commitments.

Conclusions

Successes and failures were encountered in the method used. At least one person who was screened and found to have significant risk factors died due to coronary occlusion (medical examiner's report) before referral to his physician was accomplished. Contrasting this failure is the gratifying knowledge that a number of previously obese, heavy smokers have proved that motivated persons can indeed lose weight and stop smoking at the same time. Response to referral letters has not been 100 percent. Response to physician's advice has not been 100 percent. Statistical analyses have not been attempted for obvious reasons.

Continued clinics are currently planned on a one-Saturday-morning-per-month basis. It is expected that better utilization of dietary, nursing, and physical education personnel will prevail in future follow-up activities. The long-term benefits of such a continued program seem obvious. Modifications of methodology and/or inclusion of other screening procedures such as diabetes, thyroid disease, anemia, and the like, would seem to be logical extensions of such a program. □

LaFayette County Heart-Risk Screening Program

Registration and Screening Results

Name_____ Birthdate: Month [ ] Day [ ] Year [ ]

Place of Birth: County_____ State_____ [ ]

Current Address:_____ Telephone No._____

Personal Physician:_____

Address of Physician:_____

Risk Factors:

Cigarette Smoking	Non-smoker [ ] 1	< 2 packs [ ] 2	2+ packs [ ] 3	
Exercise Level	Least [ ] 1	Medium [ ] 2	Most [ ] 3	
Diabetes History				
Family History	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	
Self	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	
Heart Disease				
Family, Premature	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	
Self	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	
Blood Pressure [ ][ ][ ]/[ ][ ][ ]				
Known Hypertension	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	
Current Treated Hypertension	Yes [ ] 1	No [ ] 2	Don't Know [ ] 3	

Height [ ][ ] inches Weight [ ][ ][ ] lbs.

Cholesterol [ ][ ][ ] mg% N.D. [ ] T.D. [ ]

Triglycerides [ ][ ][ ] mg%

Clinic Counseling:

Offered	Yes [ ]	No [ ]	
Done	Yes [ ]	No [ ]	
If Yes	MD [ ]	PHN [ ]	Other [ ]

Figure 1

When the gastritis patient has a condition requiring an analgesic, a new problem arises. Aspirin's irritating effect on the gastric mucosa is well documented.[1-3]

TYLENOL (acetaminophen), on the other hand, is unlikely to cause local irritation,[2,3] which is why it is preferred in the patient subject to gastritis.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Muir, A., and Cossar, I.A. Brit. Med. J. *2*:7-12 (July 2) 1955. **2.** Vickers, F.N.: Gastroint. Endosc. *14*:94-99 (Nov.) 1967. **3.** Roth, J.L.A.: Med. Clin. N. Amer. *41*:1517-1537 (Nov.) 1957.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relie of pain and fever

Tylenol
(acetaminophen)

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Placidyl®
ETHCHLORVYNOL)

Brief Summary

ndications—Placidyl (ethchlorvynol) is indicated s short-term hypnotic therapy in the management f insomnia.

ontraindications—Drug hypersensitivity and porhyria.

/arnings—Not recommended during the first and econd trimester of pregnancy. Caution patients f possible combined exaggerated effects with lcohol, barbiturates, tranquilizers or other CNS epressants. Exaggerated effects might result in lurring of vision, paralysis of accommodation and rofound hypnosis. Caution patients concerning rlving a motor vehicle, operating machinery, or ther hazardous operations requiring alertness afer taking the drug. ADMINISTER WITH CAUTION O PATIENTS WITH SUICIDAL TENDENCIES AND O NOT PRESCRIBE LARGE QUANTITIES OF THE RUG. Adjustment of the dosage of oral anticoagilants might be necessary when beginning ethchlorynol therapy, during therapy, or after stopping erapy. This drug is not recommended for use in ildren. PLACIDYL HAS THE POTENTIAL FOR HE DEVELOPMENT OF PSYCHOLOGICAL AND HYSICAL DEPENDENCE. INSTANCES OF SEERE WITHDRAWAL SYMPTOMS, INCLUDING ONVULSIONS AND DELIRIUM CLINICALLY SIMAR TO THOSE SEEN WITH BARBITURATES, AVE BEEN REPORTED IN PATIENTS TAKING EGULAR DOSES AS LOW AS 1000 MG. PER DAY VER A PERIOD OF TIME WHEN THE DRUG WAS UDDENLY DISCONTINUED. PROLONGED ADINISTRATION OF THE DRUG IS NOT RECOMENDED. Addiction-prone patients or those who e likely to increase dosages of the drug on their wn initiative should be observed for evidence of gns or symptoms which may indicate possible rly withdrawal or abstinence symptoms. Signs d symptoms associated with withdrawal and abinence include unusual anxiety, tremor, ataxia, urring of speech, memory loss, perceptual disrtions, irritability, agitation and delirium. Other ss well defined signs and symptoms, not necesrily due to withdrawal and abstinence, may inude anorexia, nausea or vomiting, weakness, zziness, sweating, muscle twitching and weight ss. Abrupt discontinuance of Placidyl following olonged overdosage may result in convulsions d delirium.

ecautions—Toxic amblyopia has been reported th long-term continuous use of ethchlorvynol. rmanent visual defects have been observed, alough amblyopia has improved after discontinuan of the drug. Drug dosage should be limited elderly and debilitated patients to the smallest ective amount. If pain is present, this drug ould only be given if insomnia persists after In is controlled with analgesics. Caution is ased in prescribing the drug for patients who are ing treated with either MAO inhibitors or antipressants. Transient delirium has been reported th the combination of Placidyl and amitryptyline. ug dosage should be reduced if prescribed for tients receiving MAO inhibitors or antidepresnts. Caution should be exercised in patients th impaired hepatic or renal function. Patients o respond unpredictably to barbiturates or alcol, or who exhibit excitement and release of inhiion in association with such agents, may also ct In this way to Placidyl. Rarely, patients may ibit symptoms suggestive of an unusual susptibility to the drug; such as prolonged hypnosis, found muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient ldiness or ataxia may occur.

verse Reactions—Hypotension, nausea or vomg, gastric upset, aftertaste, blurring of vision, ziness, facial numbness, and allergic reaction ified by urticaria have been reported following cidyl administration. Mild "hangover" and sympns of mild excitation have occurred in some ients. There have been rare reports of cholestatic ndice occurring in patients taking ethchlorvynol. few cases of thrombocytopenia have been reted in patients receiving ethchlorvynol. 307454

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Removal of Catheter Embolus from Right Pulmonary Artery

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Fond du Lac, Wisconsin

THE USE OF INDWELLING polyethylene venous catheters is increasing in our hospitals as they are employed for intravenous fluid therapy, central venous pressure monitoring, hyperalimentation, and the like. Usually such catheters are introduced through the lumen of a needle. After the initial venapuncture is made and the catheter inserted, the needle is withdrawn and taped to the adjacent skin with the catheter still passing through the sharpened end of the needle. An ever present hazard is the possibility that the catheter may be severed by the sharp end of the needle so that the fragment so formed is free to slide into the vein and lodge in some intrathoracic structure. Numerous thoracotomies have been performed for the removal of such catheter fragments from the vena cava, from the cardiac chambers, or from the pulmonary vessels.

In 1969, Curry[1] proposed a method for removing catheter or guide wire fragments from the vascular system by means of passing a long fine guide wire which had been folded double through a larger catheter to snare the embolized fragment. Curry had not actually employed this device at the time he suggested its use, and he apparently was unaware that in 1967 Massumi and Ross[2] had reported the use of exactly such a device to successfully remove a catheter fragment from the vena cava.

In 1971, Dotter, et al[3] reviewed 29 cases in which guide wire and catheter fragments were removed by nonsurgical transluminal retrieval methods. Most of these fragments were removed by the loop snare method. In only two of these cases, however, were relatively small fragments removed from the right or left pulmonary artery; these two cases were reported by Miller, et al.[4] These authors used a dou-

From St. Agnes Hospital, Fond du Lac.
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bled .021 inch guide wire passed through an 8 F catheter in both their cases employing an approach via the right brachial vein in one and the right subclavian vein in the other. Subsequently, Liss and Crago[5] reported a third case in which a polyethylene catheter fragment was removed from the left pulmonary artery by means of a doubled .035 inch guide wire passed through a 9 F Lehman catheter introduced via a cutdown on the right basilic vein.

The following case is a fourth instance of the transluminal retrieval of a catheter fragment from one of the pulmonary arteries; it demonstrates the feasibility of this method of treatment.

Case Report

A 56-year-old female was admitted with severe abdominal pain which subsequently was found to be due to a stone in the left ureter. To facilitate intravenous infusion, a 22-gauge intracatheter 8 inches long was introduced into the left antecubital vein. The catheter was apparently severed by the sharp end of the needle, and a 5½-inch segment of catheter embolized into the right pulmonary artery (Fig 1). An attempt was made to retrieve the catheter via a cutdown on the right brachial vein, using a 7 F Goodale-Lubin catheter and a folded .021 inch guide wire. Although the guide wire passed through the catheter easily outside the body, when the catheter tip was inserted into the right pulmonary artery, it was not possible to push the guide wire through the catheter. An 8 F Teflon catheter was then inserted through the cutdown, but we were unable to advance the tip of this catheter into the pulmonary artery.

Figure 1—Arrows indicate a 5½-inch segment of catheter embolized into the right pulmonary artery.

Three days later, an 8 F Teflon catheter (Cook, Inc) was inserted percutaneously into the femoral vein over a .054 inch guide wire. The catheter passed readily into the pulmonary artery, but required a deflector tip to advance it into the right pulmonary artery. The doubled .021 inch guide wire passed easily through the Y-connector and the catheter. About 20 minutes of manipulation was necessary before the foreign body was snared and removed. It is interesting to note that the polyethylene catheter fragment was pulled out through the Teflon catheter and Y-connector.

Comment

It seems obvious that percutaneous retrieval of intravascular foreign bodies is preferable to direct surgical removal by thoracotomy. This point is emphasized by Hipona, et al[6] in their recent excellent review of this subject. The retrieval apparatus currently available commercially is evidently quite suitable for such transluminal removal, even from the pulmonary artery. It would probably be desirable for angiographic laboratories to keep such equipment on hand.

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Discreet Diagnoses

The physician's role in hospital admission of an alcoholic patient under some other diagnosis was criticized by Dr. Marvin A. Block, assistant professor of clinical medicine at the State University of New York in Buffalo. In MEDICAL WORLD NEWS, Dr. Block said, "This is unfair to the family, the hospital, the nursing staff, and the patient. It helps the patient deny the problem, and the patient has been doing this for years." On occasion, Dr. Block suggested, the physician's attitude may not be entirely unprejudiced. "It's very difficult for a doctor to label anyone alcoholic who drinks less than he (the doctor) does." □

Interpretation and Significance of Immunofluorescence Microscopy of Kidney Biopsies

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UNDERSTANDING OF GLOMULAR diseases has advanced rapidly over the past twenty years since introduction of the percutaneous renal biopsy technique. The relative ease of obtaining renal tissue by this method has enabled nephrologists and pathologists to observe early histopathologic alterations, render more accurate diagnosis, appreciate pathogenetic history, and evaluate effectiveness of selected therapies in renal glomerular diseases. In addition, improvements in histologic techniques, including thin sectioning and new special stains, as well as use of the electron microscope to define ultrastructural changes, have contributed to diagnostic accuracy and further understanding of renal disease.[1]

In conjunction with this improved understanding of morphology, considerable information has accumulated regarding immunologic mechanisms in human glomerulonephritis. An immune etiology in proliferative glomerulonephritis, first suspected because of the latent period in poststreptococcal glomerulonephritis,[2] has been supported by the finding of low-complement levels in some forms of glomerulonephritis[3] and by many experiments with animal models.[4]

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Lawrence R. Hyman was a National Institutes of Health Special Postdoctoral Fellow, 1-F03-AM-53086.

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In 1956 Mellors and Ortega reported finding immunoglobulins in diseased glomeruli using an immunofluorescence technique.[5] This prompted the application of immunofluorescence methods to routine study of renal biopsies over the last decade.[6,7]

Our experience with this technique at the University of Wisconsin Center for Health Sciences now includes studies in excess of 1,000 renal biopsies. From this experience we have reached certain conclusions about the value of immunofluorescence microscopy at its present stage of development in study of renal diseases.

This report reviews the methodology of the immunofluorescence technique, defines its limitations, and discusses those conditions in which it is now most useful in the diagnosis of renal disease.

Antibodies to various human immunoglobulins, complement components, fibrinogen, properdin, and albumin are purchased commercially or prepared in our laboratories by immunization of experimental animals with selected purified plasma proteins. After conjugation of the immunoglobulin fraction of these immune sera with fluorescein isothiocyanate,[8] these various antibodies are incubated with frozen sections of unfixed renal tissue. The fluorescent antibodies become fixed at sites of respectively specific plasma protein antigens present in the tissue. The sections are then washed to remove unattached fluorescent materials, mounted with buffered glycerin, and examined with an ultraviolet microscope equipped with selected filters designed to achieve appropriate illumination. Sites of bound fluorescein labeled antibodies will appear bright yellow-green indicating the presence of a protein antigen corresponding to the specific antibody used.

At present, fluorescent antibodies monospecifically reactive with five classes of immunoglobulins (IgG, IgA, IgM, IgD, IgE), two complement components, C_4 and C_3 (β1C globulin), fibrin, properdin (a serum euglobulin), and albumin have been used in our laboratories for the study of kidney specimens. In addition an *in vitro* immunohistologic complement-fixation test is used to verify the complement-fixing properties of immunoglobulin containing aggregates in tissues.[9,10] For each of these immunohistochemical-staining reagents and reac-

tions, there are a variety of control reactions utilized to validate the specificity of the resulting fluorescence microscopic findings.

Deposition of immunoglobulins or other plasma proteins in glomeruli may be continuous or interrupted, linear or granular, segmental or diffuse, along the peripheral capillary basement membranes, in the mesangium, or along Bowman's capsule. In addition, plasma proteins may be seen in tubular casts, within tubular epithelial cells, along tubular basement membranes, and in the walls of blood vessels.

Even though some differentiation of glomerular diseases may be achieved on the basis of patterns of glomerular deposition of plasma proteins, it should be emphasized that the fluorescent antibody technique is not simply another tissue stain. While results of immunohistochemical examination of renal biopsies provide additional morphologic information, their greater importance relates to what may be inferred about the immunopathogenesis of glomerular injury. As noted above, immunopathologic study of diseased human kidneys, as well as of diseased kidneys in experimental animal models, strongly supports the concept that many glomerular diseases have an immunologic basis.

From such correlative studies, two distinct types of immunologic mechanisms of glomerular injury are apparent. In the first type, variable degrees of renal damage result from acute, recurrent, or persistent passive deposition of antigen-antibody complexes in the glomerulus. Although the specific antigens involved may not be known, they have been defined in certain diseases. For example, streptococcal cell wall antigens have been identified in post-streptococcal glomerulonephritis,[11] staphyloccal antigens in ventriculo-atrial shunt nephritis,[12] nuclear antigens in lupus glomerulonephritis,[13] malarial antigens in nephrotic syndrome associated with quartan malaria,[14] and recently Australia antigen in glomerulonephritis associated with serum hepatitis.[15] In these specific diseases the pattern of immunoglobulin and complement deposition is characterized by discreet, granular or globular deposits of variable density and pattern of distribution along the glomerular capillary walls. Thus, a granular pattern of immunofluorescent localization of immunoglobulins and complement components in glomeruli is presumptive evidence for an immune-complex etiology even though the specific antigen may not be identified.

In the second type of immunologically mediated injury, antibodies reactive against glomerular basement membrane antigens localize along glomerular capillary walls. In these patients the fluorescent antibody pattern consists of a diffuse, smooth, linear deposition, usually of IgG, along the glomerular capillary walls. An example of this is Goodpasture's syndrome (rapidly progressive crescentic glomerulonephritis with lung purpura), a disease analogous to Steblay's experimental "autoimmune" glomerulonephritis in sheep.[16] While these two mechanisms, immune-complex and anti-glomerular basement membrane reactions, are now clearly recognized, they do not explain all forms of glomerular disease in which plasma proteins are localized in glomerular tufts.

It has recently been postulated that serum properdin, either activated in the blood or localized in glomerular capillary walls in the *absence* of immune complexes or anti-glomerular basement antibodies, activates the complement cascade at the C_3 level, bypassing C_1, C_4 and C_2. Thus, properdin can initiate the classic inflammatory response and subsequent glomerular injury without having progressed through several of the initial steps in the usual sequence of complement activation.[17] In addition, fibrin formation and deposition in glomerular capillaries plays an important role in the pathogenesis of some glomerular lesions as evidenced by the frequent finding of fibrin in various glomerulonephropathies.[18]

While immunofluorescence examination of renal biopsies has provided assistance in differential diagnosis and added much to our knowledge of renal diseases, there are limitations and controversies that must be considered with respect to interpretation of results. Some problems derive from lack of immunologic specificity, cross reactions, and unspecific protein interactions potentially inherent in immunohistochemical reactions. Furthermore, the mere identification of serum proteins in diseased glomeruli is not proof of, but rather inferential evidence for their causative role in the disease.

Metabolic consumption or removal of antibody could account for negative fluorescent findings in some presumably immunologically mediated forms of glomerulonephritis. Alternatively, immunofluorescent techniques may not be sensitive enough, or glomerular lesions may be caused by substances as yet unidentifiable by current immunofluorescence methods. Identical or similar glomerular lesions might have different immunofluorescence-staining results or, conversely, renal lesions with different etiologies or histologic alterations may have similar immunofluorescence appearances. The possibility that immunoglobulins may be deposited in capillaries as a result rather than as the cause of glomerular injury must also be considered in interpretation of immunofluorescence studies.

In some patients with diabetic glomerulosclerosis, lupus nephritis, and polyarteritis involving the kidney, there is linear deposition of IgG along the glomerular basement membrane, but this immunoglobulin does not show immunologic reactivity with glomerular basement membrane antigens.[19] Despite the above considerations which dictate caution in interpretation of data, immunofluorescent studies are essential in histopathologic diagnosis of some conditions. In others, immunofluorescence patterns may be characteristic but not specific or essential in diagnosis. Some characteristic and diagnostically helpful immunofluorescence patterns are the following:

1. *Absence of deposits detectable by immunofluorescence in a patient with nephrotic syndrome and only minimal glomerular changes on light microscopy.* This pattern is characteristic of lipoid nephrosis. Pathologists refer to this disease as "minimal lesion nephrotic syndrome" or "nil disease." This is the type of lesion commonly seen in childhood nephrotic syndrome.

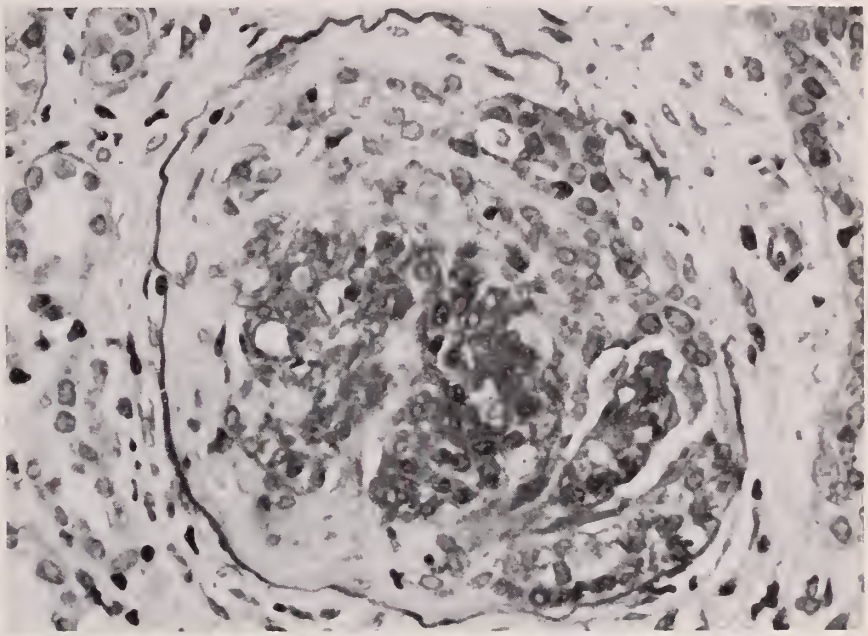

Figure 1A—Crescentic nephritis. (PAS x 350). Twenty-year-old white male who presented with hematuria, hemoptysis, and rapidly deteriorating kidney function. On light microscopy there were multiple capsular epithelial crescents compressing the glomerular tuft.

Figure 1B—Immunofluorescence staining of this biopsy with anti-IgG revealed a fine linear pattern indicating the presence of antibodies directed against or cross-reacting with the glomerular basement membrane. Diagnosis, Goodpasture's syndrome. (Magnification x 525)

2. *Diffuse intense linear deposition of IgG with variable deposition of β1C globulin along glomerular basement membrane.* This pattern is *diagnostic* of anti-GBM associated glomerulonephritis and is seen in patients with Goodpasture's syndrome and in some other cases of rapidly progressive, crescentic glomerulonephritis (Fig 1A and 1B). Faint linear glomerular capillary staining for immunoglobulin G occasionally may be found in patients with lipoid nephrosis, systemic lupus erythematosis, or diabetic nephropathy.
3. *Diffuse heavy granular deposits of immunoglobulin G and β1C globulin along all capillary basement membranes in patients with nephrotic syndrome.* This pattern is *characteristic* of membranous glomerulonephropathy. In some patients with this disease, particularly in early stages, the light microscopic changes may be minimal or equivocal. It is in these

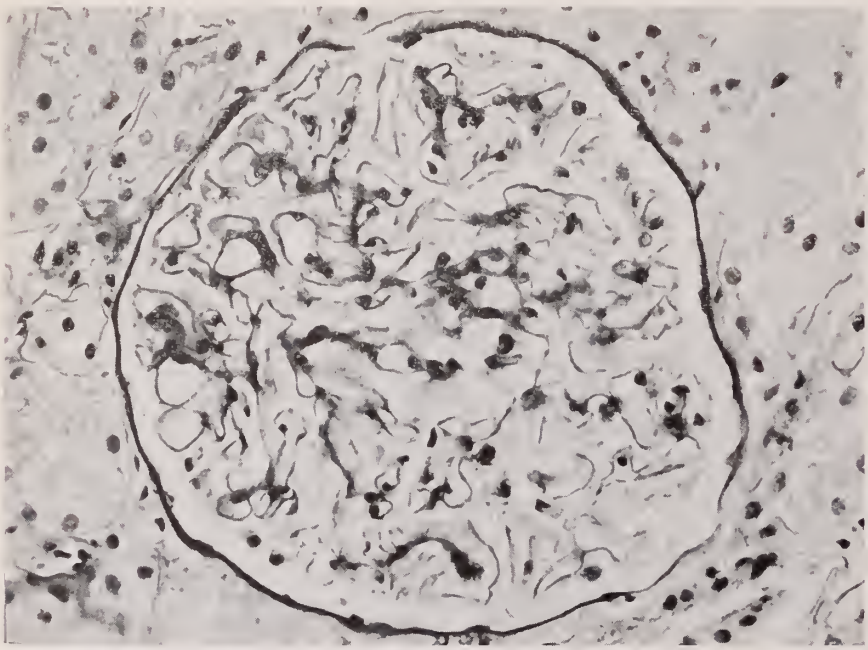

Figure 2A—Membranous glomerulonephropathy (H and E x 275). Thirty-five-year-old white male with nephrotic syndrome and no other serologic abnormalities. By light microscopy this biopsy appeared normal.

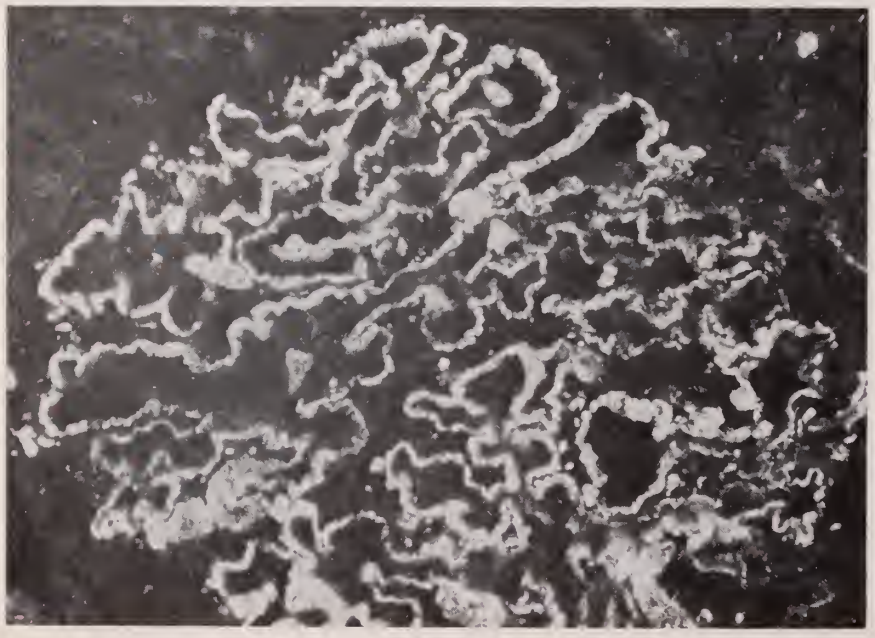

Figure 2B—Frozen section of the above biopsy stained with fluorescent anti-IgG. Note heavy deposition of IgG along the peripheral capillary walls. In this situation the presence of immunoglobulin strongly suggests the pathologic diagnosis of membranous glomerulonephropathy. Electron microscopy confirmed this impression. (Magnification x 450)

patients with early membranous glomerulonephropathy that immunofluorescent studies are particularly useful in identifying the true nature of the nephrotic lesion (Fig 2A and 2B).

4. *Extensive deposits of C3 and properdin along the basement membrane and in the mesangial region, with or without other immunoglobulins.* This pattern is seen in membranoproliferative glomerulonephritis and is often accompanied by hypocomplementemia[20] (Fig 3A and 3B).

5. *Segmental or diffuse mesangial deposits of IgA, IgG, and β1C globulins.* This pattern, observed in a glomerulonephropathy recently described by Berger, suggests an entity unrecognized before the introduction of immunofluorescence.[21] The light microscopic picture is variable with the predominant lesion being a focal proliferative glomerulonephritis. Clinically it usually has a relatively benign course characterized by recurrent attacks of microscopic or macroscopic hematuria and slight proteinuria (Fig 4A and 4B).

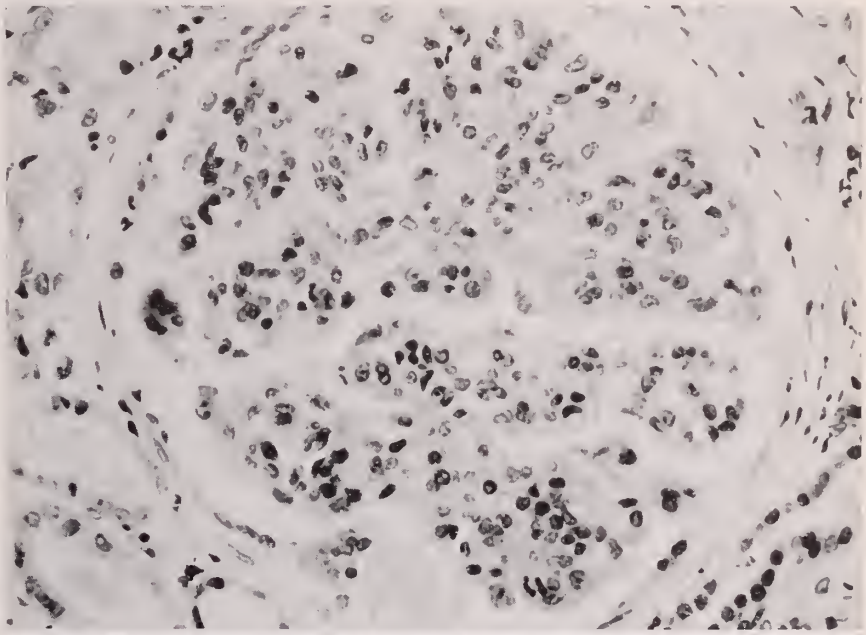

Figure 3A—Membranoproliferative glomerulonephropathy (H and E x 325). Seventeen-year-old white male with nephrotic syndrome, hematuria, and decreased β_1C globulin in his serum. This section demonstrates diffuse thickening of the peripheral capillary walls along with lobularity due to cellular proliferation in the glomerulus.

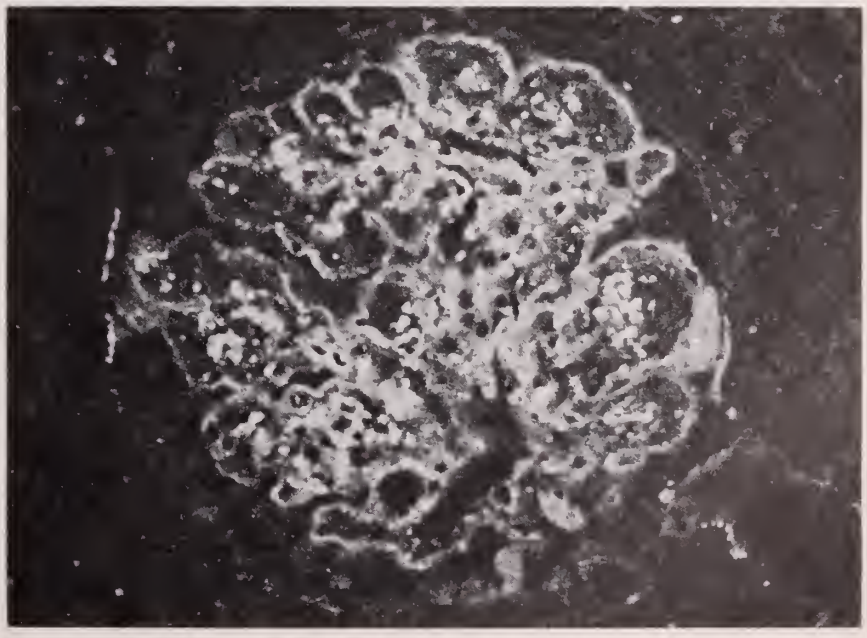

Figure 3B—Immunofluorescence staining of this biopsy with anti-C_3. Note heavy granular deposits along capillary loops. Properdin and IgG immunoglobulin were also present. C_4, a complement component activited before C_3 in the usual complement cascade, was not present in this biopsy (see text). (Magnification x 260)

While the above patterns are more or less diagnostic of particular entities, there are many instances where immunofluorescence gives us clues which, while not diagnostic, are helpful in confirming or rejecting a proposed diagnosis. For example, in hereditary forms of nephritis such as Alport's syndrome, immunofluorescence is minimal or negative except for the paradoxical presence of β1C-globulin.[22] Likewise, there is usually no glomerular deposition of immunoglobulins in rejection of renal homotransplants; whereas, recurrence of glomerulonephritis, such as membranoproliferative glomerulonephritis in the transplanted kidney may be associated with glomerular bound immunoglobulins, complement, and properdin.

The nephritis associated with Henoch–Schöenlein purpura is typically characterized by diffuse deposits of IgA, IgG, C_3, C_4 and variable degrees of IgM. Finally, simultaneous heavy deposition of the three principle immunoglobulins (IgG, IgA, and IgM) as well as C_3, C_4, and properdin is highly indicative of lupus glomerulonephritis. In addition, in some

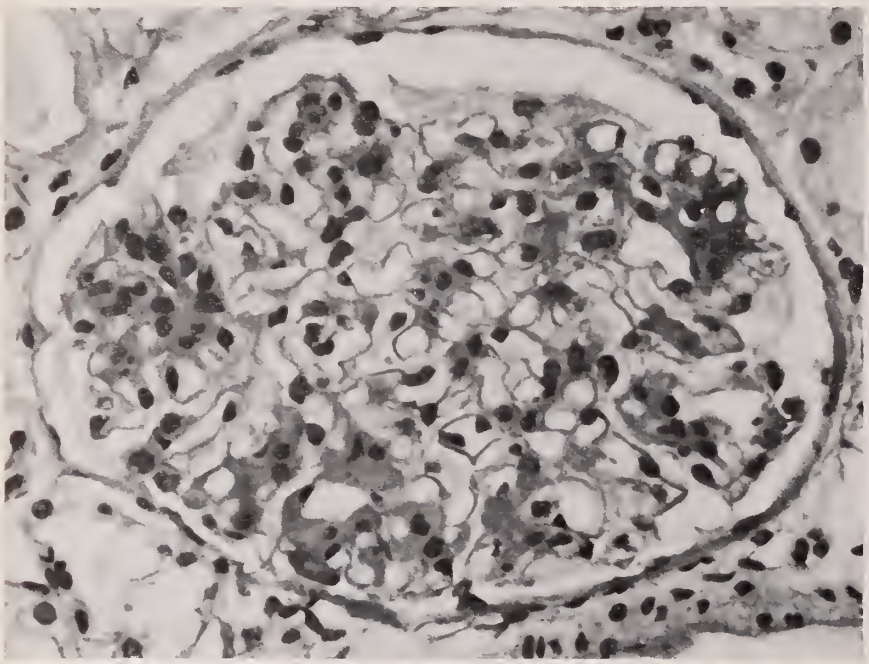

Figure 4A—IgA–IgG glomerulonephropathy (PAS x 350). Forty-four-year-old white male with asymptomatic hematuria. This section demonstrates segmental increase in glomerular mesangial cellularity and membrane matrix.

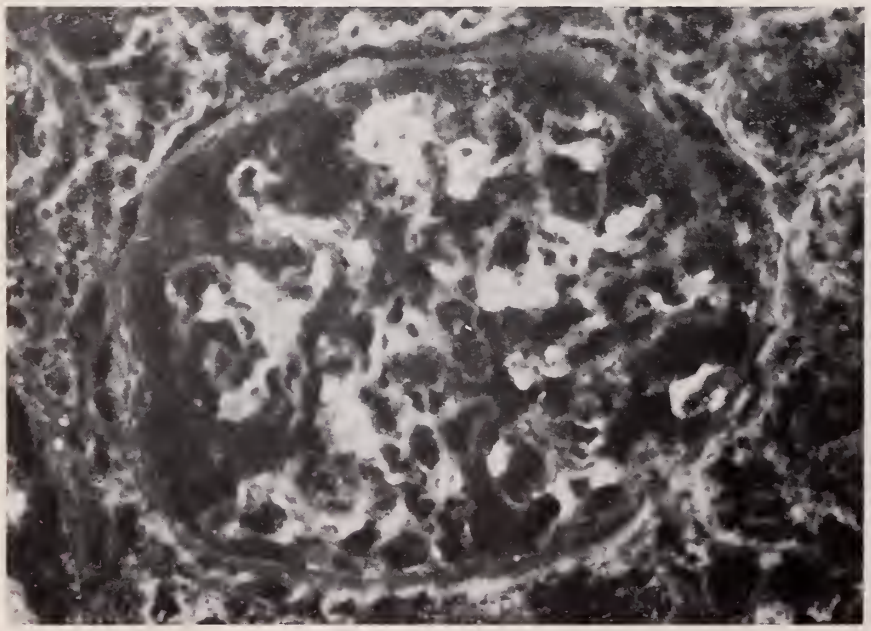

Figure 4B—This biopsy, when stained with anti-IgA sera, revealed large deposits of IgA immunoglobulin in the mesangial regions corresponding to areas of increased mesangial matrix. The light microscopic picture along with the presence of IgG and C_3 make the presumptive diagnosis of IgA–IgG glomerulonephropathy. (Magnification x 400)

forms of chronic glomerulonephritis these immunoglobulins and complement components may be present in glomerular deposits with a preponderance of IgM.

Conclusion

Immunofluorescent staining of renal biopsies has become an integral part of the diagnostic armamentarium in clinicopathologic evaluation of glomerular disease. In anti-glomerular basement membrane antibody-mediated glomerulonephritis, membranous glomerulonephropathy, IgG-IgA nephropathy, and membranoproliferative glomerulonephritis, immunofluorescent patterns contribute substantially to differential diagnoses. Absence of glomerular immunoglobulin and complement deposits are characteristic of lipoid nephrosis, hereditary nephritis (except for the presence of β_1C globulin), and renal transplant rejection uncomplicated by recurrent glomerular disease. In some conditions such as lupus glomerulonephritis, chronic glomerulonephritis, and Henoch–Schöenlein nephropathy, the deposition of multiple immunoglobulins is characteristic though not diagnostic. Besides these practical diagnostic features, immunofluorescent study of renal biopsies is an investigative tool of valuable potential in the search for plasma proteins and other endogenous or exogenous antigens which may be important in the pathogenesis of glomerular injury.

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Barbiturate Drugs

The Food and Drug Administration April 30, 1973 recommended tighter controls for nine barbiturate drugs. Three of the sedatives—amobarbital, secobarbital, and pentobarbital—rank among the ten most abused drugs in the United States.

These popular "downers" are known by such street names as "blue devils", "red birds", "yellow jackets".

The remaining six barbiturates are butabarbital, cyclobarbital, heptabarbital, probarbital, talbutal, and vinbarbital.

The nine barbiturates, all short-to-intermediate acting sedatives, are currently regulated under Schedule III of the Controlled Substances Act. FDA's recommendation to the Bureau of Narcotics and Dangerous Drugs (BNDD), which administers the Act, is that all nine drugs in all dosage forms be moved to Schedule II.

If, as expected, BNDD acts on the FDA recommendation, the drugs would become as tightly controlled as amphetamines and morphine and other drugs that have a high potential for abuse yet also have important medical uses.

Schedule II controls include limits on quantities that may be manufactured each year; no refills on prescriptions; and accurate records of sales or use.

BNDD has gathered evidence of extensive diversion of amobarbital, secobarbital, and pentobarbital. This evidence served as a basis for the FDA recommendation. The Bureau's report also showed the need for tighter control of the other six barbiturate drugs mentioned in the FDA recommendation because they have similar chemical and biological properties and, thus, similar abuse potential.

For the 12-months from April, 1971, to April, 1972, BNDD reported thefts of barbiturates totaling 7,328,521 dosage units. An average single dose is 100 milligrams. □

CASE REPORT

Eosinophilic Gastroenteritis

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Although the number of reported cases of eosinophilic gastroenteritis is limited, this disease entity is probably not uncommon. Our patient is being reported to alert the physician to consider eosinophilic gastroenteritis in a young individual who presents with a gastric outlet syndrome. Surgery can be avoided if the diagnosis is established by roentgen studies, gastroscopy, and biopsy. Prompt response to steroid therapy may be anticipated. A past history of allergic bronchitis and peripheral eosinophilia should be sought.

EOSINOPHILIC INFILTRATION of the stomach wall was first reported by Kaijser[1] in 1937. In 1948, Barrie and Anderson[2] described involvement of more than one segment of the gastrointestinal tract. Ureles, *et al*[3] classified this entity by dividing it into two categories; namely, diffuse eosinophilic gastroenteritis and circumscribed eosinophilic infiltrative granuloma (the latter being found in older patients who do not present with peripheral eosinophilia). Further, they divided eosinophilic gastroenteritis into polyenteric, monoenteric, and regional types. Our patient had the polyenteric type, which is characterized by extensive thickening and induration of the antrum of the stomach and small intestine.

The clinical manifestations of eosinophilic gastroenteritis vary with the area of involvement, but pyloroduodenal obstruction is the hallmark of the disorder. When such obstruction is encountered, the inclusion of eosinophilic gastroenteritis in the differential may permit diagnosis by peroral biopsy and allow therapy by steroid.

From the Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education, Marshfield.

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Case Report

A 31-year-old white man was admitted to the hospital on Aug. 31, 1972, with the chief complaint of feeling bloated for ten days and vomiting large amounts of food during that time. Questioning revealed that the patient had been troubled by belching and heartburn without any abdominal pain, anorexia, weight loss, or change of bowel habit since 1961. In 1964 the patient was treated for acute allergic bronchitis and still suffers infrequent episodes of coughing and wheezing, particularly after exertion in cold weather. In 1967 he was seen as an outpatient for persistent vomiting. At that time roentgen studies of the upper gastrointestinal tract showed marked pylorospasm and only fragmentary filling of the small intestine. Subjective evidence of the disease subsided during the next ten days in response to symptomatic treatment.

Examination disclosed a well developed and nourished man who did not appear ill. Physical findings were: pulse rate, 78 beats per minute; blood pressure, 130/97 mm Hg; respirations, 18 per minute; and temperature, 36.9 C (98.4 F). The abdomen was distended mainly above the umbilicus, and succession splash was elicited. The abdomen was not tender; bowel sounds were normal; hepatosplenomegaly was lacking; and the remainder of the physical examination was normal.

Laboratory results included hemoglobin 16.7 Gm per 100 ml, hematocrit 48.6 vol %, white blood cell count 10,700 per cu mm with neutrophils 53%, lymphocytes 28%, monocytes 6%, and eosinophils 13%. Red blood cell morphology and platelets were normal.

Normal or negative laboratory results included blood sugar, calcium, phosphorus, uric acid, cholesterol, bilirubin, blood urea nitrogen, lactic dehydrogenase (LDH), serum glutamic oxaloacetic transaminase (SGOT), urinary and serum amylase, lupus erythematosus preparation, antinuclear antibody, chest roentgenogram, electrocardiogram, and stool examination for eggs and parasites. Results of protein electrophoresis were total protein 7.7. Gm per 100 ml, albumin 3.18 Gm per 100 ml, and globulins normal.

X-ray films of the upper gastrointestinal tract disclosed pyloric duodenal obstruction with no emptying in 40 minutes.

Results of proctoscopy, roentgen examination of the intestine following barium enema, and intravenous pyelogram were not remarkable. The terminal ileum was not visualized.

The patient was treated with gastric suction and intravenous fluids for nine days, during which time the outlet obstruction persisted. Total gastric drainage varied between 1500 and 2500 ml daily.

Nine days after admission exploratory laparotomy disclosed marked thickening of the entire gastric wall and pylorus. The entire small intestine was inflamed and edematous but lacked evidence of peptic ulcer disease. Biopsy of the stomach (Fig 1), pyloric wall (Fig 2), and duodenum (Fig 3) confirmed the findings of eosinophilic gastroenteritis.

Following elective vagotomy and pyloroplasty, the postoperative course was uncomplicated. The patient had no gastrointestinal tract complaints at follow-up eight months after surgery. Significantly the eosinophil count increased to 37% postoperatively and was still 33% when the patient was discharged.

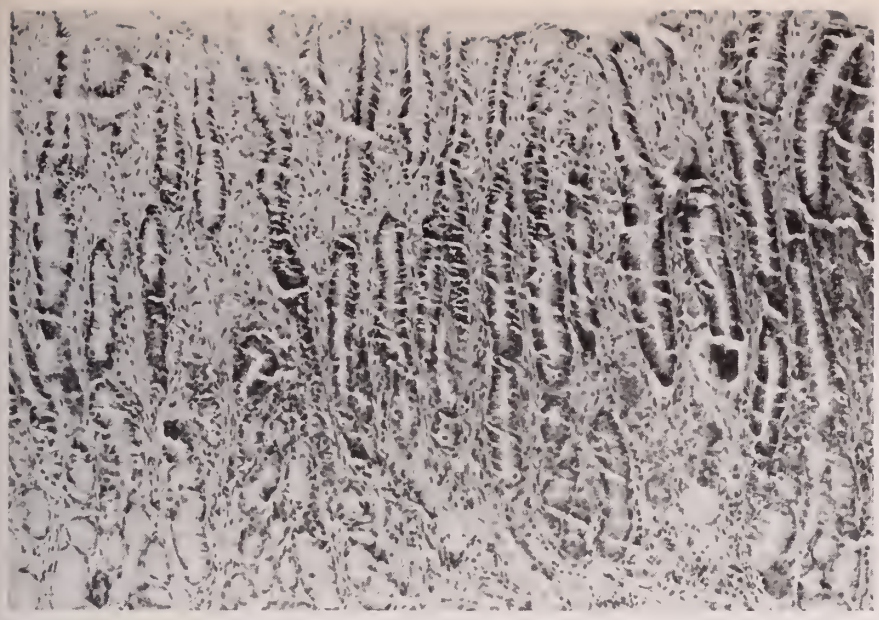

Figure 1 — Intact pyloric mucosa without eosinophilic infiltration (hematoxylin and eosin stain, x 100).

Figure 2 — Splitting of muscularis propria of pylorus by bands of eosinophils (hematoxylin and eosin stain, x 100).

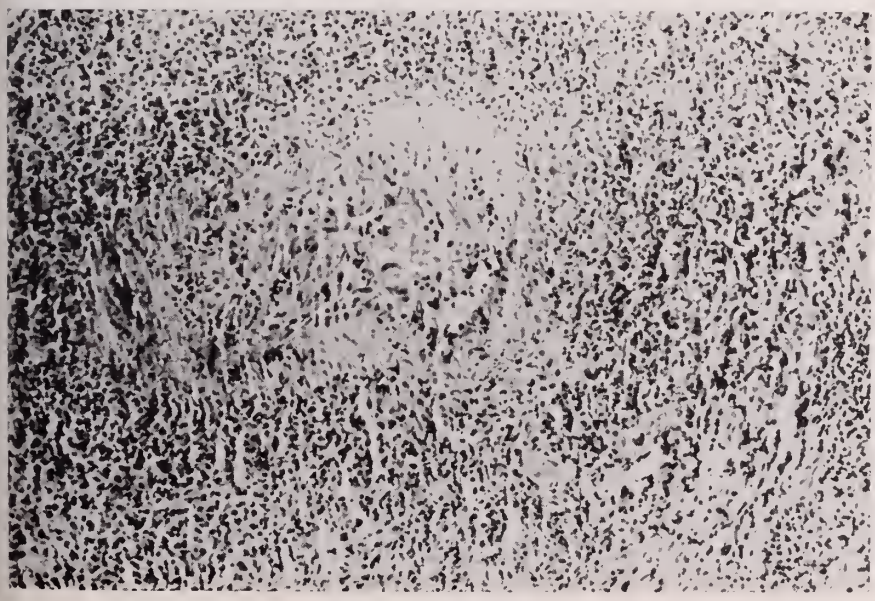

Figure 3 — Necrotizing eosinophilic arteritis in wall of duodenum (hematoxylin and eosin stain, x 100).

Discussion

Pathologically, eosinophilic gastroenteritis is characterized by a diffuse, chronic, inflammatory infiltrate extending from the submucosa up to (and at times including) the serosa. Composed predominantly of eosinophils, the infiltrate splits the muscle bundles of the muscularis and surrounds periarterial connective tissue (Fig. 3).

Klein, *et al*[4] have proposed a recent classification for this disease based on the anatomic distribution of the eosinophilic infiltrate. They describe predominantly mucosal disease, predominantly muscle-layer disease, and predominantly subserosal disease. The first category comprises cases in which iron-deficiency anemia with fecal blood loss, diarrhea, and protein-losing gastroenteropathy are the major clinical findings. Patients with predominantly muscle-layer disease have marked thickening and rigidity of the intestinal wall. In this group, involvement of the stomach and pylorus produces obstruction, whereas involvement of the small intestine mimics regional enteritis. Subserosal disease produces eosinophilic ascites.

The etiology of eosinophilic gastroenteritis is unknown, but a significant number of patients have a history of respiratory allergy, and many present with circulating eosinophilia. However, attempts to correlate the eosinophilic inflammation with dietary allergens have been unsuccessful.[5,6]

Attempts have been made to reproduce the disease in laboratory animals,[7,8] and one experimental model suggests an autoimmune mechanism.[8]

In our review of 74 reported cases,[1-7,9-11] the diagnosis was established at autopsy in 4, by ex-

SPECIAL

Status and Estimate of Needs

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WHILE "physician shortage" and "physician maldistribution" are commonly heard phrases, their meanings have not been defined clearly. Reliance upon national or statewide aggregate totals of physicians, with no regard for medical specialty, helps little in defining the extent of physician shortage and physician maldistribution in Wisconsin.[1,2]

Instead of relying upon national or state totals, the characteristics of physicians (age, specialty, distribution) must be gathered and analyzed at the county or, even more ideally, at the individual community (and its service area) level. Physician characteristics gathered at this level, together with current and projected population characteristics of a defined geographical area, provide an improved capability to assess physician status and measure future need, by medical specialty.

For one medical specialty group—Family (or General) Practice—investigators in the Family Practice Program, University of Wisconsin–Madison have combined current and projected population characteristics[3,4] and the characteristics of family doctors in an attempt to estimate the current and future need for Family Physicians in Wisconsin, *by county*. A preliminary inventory[5] and final analysis reveal that despite the use of a methodology that leans toward the conservative side, the number of additional Family Physicians that could have been utilized in 1970 was 342. By 1980, the number of additional Family Physicians needed in Wisconsin will stand at 845. By that time, nearly half of the 1119 Family Physicians seeing patients in 1973 either will be fully retired or will have reduced the size of their practices.

Within Wisconsin's individual counties and communities there are wide variations both in the numbers and characteristics of family doctors. Similarly, calculations of future need also vary considerably from county-to-county and from community-to-community. These geographical variations in numbers of Family Physicians together with future projections of population change, must be appraised if the terms "physician shortage" and "physician maldistribution" are to have any meaning that relate

This is a brief summary of a detailed analysis conducted by the investigators. Copies of the more comprehensive paper and tables will be furnished upon request. Write to: John H. Renner, MD, 777 South Mills Street, Madison, Wis. 53715.

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ploratory laparotomy in 49, by peroral biopsy in 8, and by radiographic signs and favorable response to corticosteroids in 14. Familiarity with the signs and symptoms and radiological features, together with the use of peroral biopsy of either stomach or small intestine should obviate laparotomy, and a favorable response to steroids can be anticipated. The long-term prognosis is good, but repeated courses of steroid therapy may be necessary.[3,7,11]

ACKNOWLEDGEMENT: Efstathios Beltaos, MD, of the Marshfield Clinic prepared and interpreted the photomicrographs.

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for Family Physicians in Wisconsin

to the day-to-day practice of medicine in Wisconsin's communities.

Critics may well question even the mild suggestion that 342 additional Family Physicians could have been utilized in 1970 and that 845 more generalists will be required by 1980, particularly since medical specialists other than Family Physicians already administer large doses of ambulatory health care, especially in urban and suburban settings.[6] The immediate response to such criticism is that any assessment must account for the unique historical development and current and future demographic and socioeconomic characteristics of Wisconsin counties, cities, and villages. Two-thirds of Wisconsin's counties remain, and will remain, heavily rural. It is sensible that Wisconsin's approach in meeting physician manpower needs be structured to complement the existing and projected characteristics of the communities in *this* state, not those of states dissimilar to Wisconsin.

Within a defined geographical area, it is important that there are enough physicians of one medical specialty to provide coverage when a colleague is ill, is on vacation, needs a day off, or when he attends conventions or continuing education presentations. While continuity of care is an often-used if imperfectly-defined phrase, nevertheless it is clear that the Family Physician is the most appropriate specialist to maintain continuous medical care in the absence of a fellow family doctor. It is much more difficult for an Internist or a Pediatrician, especially if he is practicing in a relatively isolated location, to find a specialist like himself to cover his practice. Pediatricians, Internists, and Obstetrician–Gynecologists are not well distributed for primary care delivery across Wisconsin's 72 counties.[7]

The inventory of status and estimate of needs for Family Physicians in Wisconsin represents a positive step forward in relating physician requirements, based on medical specialty and age factors, to current and projected population statistics within a definable geographical unit. While there are methodological refinements to be worked out, even a relatively crude methodology leads to an unmistakable conclusion: there is a serious need *now* and there will continue to be a serious need for more Family Physicians, distributed on a more equitable basis among Wisconsin communities.

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Diagnosis and Treatment of Cardiac Arrhythmias

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DUE TO BETTER FACILITIES and new drugs, the diagnosis and treatment of cardiac arrhythmias has recently received greater attention. It is worth noting, however, that this has not led to a change in the general principles of treatment. Physicians should certainly not hasten to use potent drugs or potentially dangerous techniques without defining the precise nature of the rhythm disturbance requiring therapy or considering the possible consequences of interference of all drugs and techniques in the course of a treatment.

In most cases of cardiac arrhythmia little needs to be done. It is only when an arrhythmia is poorly tolerated or when it is known to presage a more serious rhythm disturbance that treatment need be instituted. The widespread availability of direct current (DC) countershock during the past decade has also made it much more reasonable to adopt a wait and see attitude in the institution of any treatment.

Atrial Rhythm Disturbances

Atrial premature beats (Fig 1A), although common, are generally asymptomatic. While they may presage atrial tachycardia, flutter or fibrillation, they do not require treatment. On examination of the patient, atrial premature beats may be distinguished by the occurrence of cannon waves in the neck, a normally split second sound and by a brief compensatory pause. The electrocardiographic diagnosis rests on the demonstration of a premature abnormal P wave preceding the ventricular complex which may be normal or may have an abnormal QRS-T configuration. If atrial premature beats are causing symptoms, they may be suppressed by sedation, or with small doses of digoxin 0.25 mg daily, or with quinidine sulfate 0.2 gm every 6 to 8 hours.

Nodal premature beats are treated in a fashion similar to atrial premature beats. Their diagnosis

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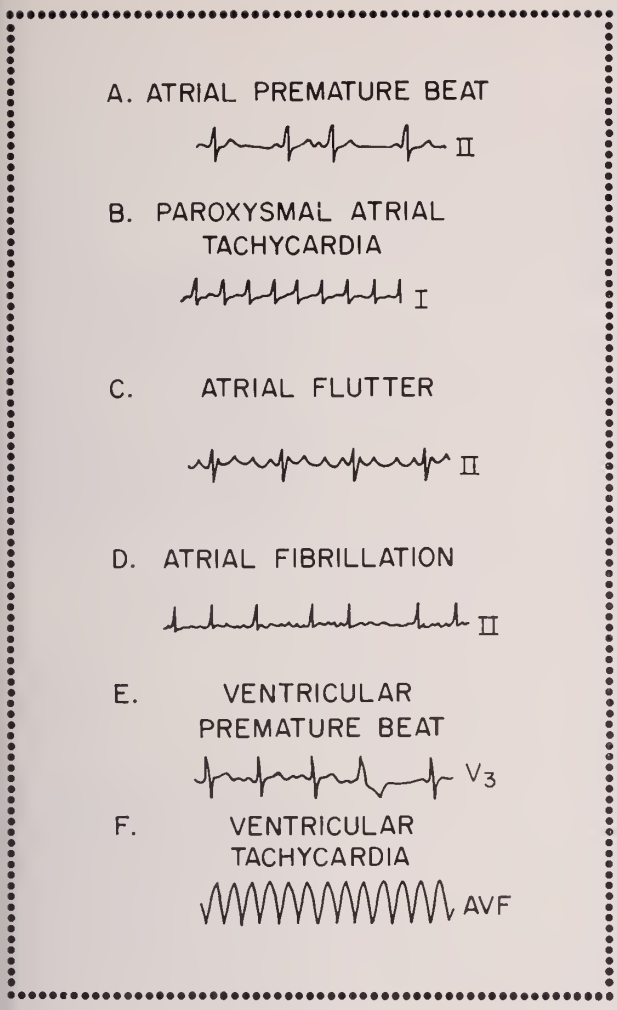

Figure 1

rests on the demonstration of inverted P waves in leads 2, 3, AVF, and an upright P in AVR. The P waves may precede the QRS complex, or may follow it.

Paroxysmal atrial tachycardia (Fig 1B) is a disturbance seen both in health and disease. It is frequently caused by excessive dosages of digitalis. In such cases it is usually seen as 2:1 AV block. Since such a rhythm disturbance is often short-lived and usually well tolerated, one should not be alarmed by its presence. It is recognized electrocardiographically by normal ventricular complexes, or if these are widened, by the presence of ectopic P waves which are not of retrograde form and are related to each QRS complex. However, if atrial tachycardia is occurring with great frequency and causing symptoms, or leading to a disturbance in cardiac function, treatment should be instituted. This can be accomplished in one of several ways. In mild cases sedatives or tranquilizers may be all that is necessary.

Vagal stimulation, which the patient can easily learn to apply by the Valsalva maneuver, or by carotid sinus stimulation, may be effective in abolishing the arrhythmia. Neostigmine, (a cholinergic drug) in a dose of 0.5 to 2.0 mg intramuscularly, or phenylephrine (a pressor amine) 5.0 mg subcutaneously, will also terminate an attack. If such measures fail, digoxin is the drug of choice. Depending upon the degree of urgency, this drug can be given orally or intravenously. For intravenous administration, a dose of 0.5 mg to be followed in one hour by a further 0.5 mg dose is usually sufficient to abolish the arrhythmia. If it does not do so completely, it usually sensitizes the carotid sinus sufficiently so that carotid massage will revert the arrhythmia.

When immediate conversion of the arrhythmia is essential, DC countershock should be instituted. Usually 50-100 Watt/seconds is adequate to revert the arrhythmia. In cases where atrial tachycardia is caused by overdosage with digitalis, the offending drug should be discontinued. Careful use of intravenous potassium may be of benefit particularly if hypokalemia is present. If the ventricular rate is very slow due to a high degree of AV block, 100 mg of diphenylhydantoin may be given intravenously in an effort to diminish the AV block. Alternately a transvenous pacer may be inserted to assure an adequate ventricular rate.

In those patients with the Wolff-Parkinson-White abnormality, propranolol has been found to be an effective agent in controlling the paroxysms of tachycardia. An oral dose of 10-20 mg every six hours may be adequate, although in some instances much higher doses are required.

Atrial flutter (Fig 1C) generally occurs in people with heart disease, and it is considered to be a rare arrhythmia. It is characterized by an atrial rate of about 300 and most often a 2:1 ratio. As in other tachycardias, once the diagnosis is established it is the urgency of the need for therapy or the need for it at all that dictates what is to be done. If cardiac output is compromised, or if there is a significant drop in blood pressure, or congestive heart failure, the method of treatment is obvious. The use of countershock, using low energy such as 20-50 Watt/seconds would be indicated. In less urgent situations digoxin is the drug of choice as it will slow the ventricular rate by increasing the degree of AV block. Often the use of digoxin will lead to the conversion of atrial flutter to atrial fibrillation which can then be converted to sinus rhythm by the addition of quinidine. The digoxin dosage should be such as is necessary to increase the AV block so that a slower ventricular rate is obtained. Intravenously that may be 0.5 mg

every two hours for three doses and then a maintenance dose of 0.25 mg intramuscularly per day.

Atrial fibrillation (Fig 1D) is a common arrhythmia. While it can be observed in persons who are otherwise normal, it usually occurs in persons suffering from rheumatic heart disease, coronary heart disease, or hypertension. The cardinal electrocardiographic features of this arrhythmia are fibrillatory waves of atrial activity and irregular ventricular response. If immediate treatment is required, it should be carried out by using synchronized DC countershock. In less urgent situations, digitalis should be administered. This will not only slow the ventricular rate but also may actually convert the arrhythmia. Once the ventricular rate is controlled, quinidine may be given to convert the fibrillation to sinus rhythm. A dosage schedule of 200 mg every two hours for five doses is usually adequate but higher dosage schedules may be necessary in more resistant cases.

In patients in whom atrial fibrillation has been chronic, and in particular those patients with a large left atrium, it is advisable to control the ventricular rate rather than to attempt to convert the arrhythmia. This is so because it is unlikely that sinus rhythm will be long-lasting. In cases where the loss of atrial transport is crucial to the maintenance of an adequate circulatory state, cardioversion should be attempted. In such cases it is preferable to have the patient treated with anticoagulants in order to minimize the incidence of emboli. Where control of ventricular rate is difficult with digoxin alone, the addition of propranolol 10 to 20 mg every six hours may be quite effective.

Disturbances of Ventricular Rhythm

Ventricular premature beats (Fig 1E) are the most common of all rhythm disturbances. They occur frequently in otherwise healthy individuals but also are manifestations of cardiac disease or digitalis overdosage. The QRS is not only premature but bizarre. Another feature is that the ST-T segment usually points in an opposite direction to the terminal portion of the QRS. In cases where there is no evidence of cardiac disease, treatment need not consist of more than reassurance or removal of such common offenders as coffee or smoking. Mild sedation, as well, may prove adequate.

When it becomes necessary to abolish ventricular premature beats by drugs, quinidine 200 mg every six hours or propranolol 10 mg every six hours, are usually effective. Procainamide 250-500 mg every six hours orally may also be useful. However, the high incidence of side effects following long-term usage of this drug has made it less desirable. Following acute myocardial infarction, ventricular premature beats should be vigorously suppressed. In such situations lidocaine as a bolus 50 to 75 mg intravenously should be administered. For long-term suppression, an intravenous drip with a dosage schedule of 1-4 mg/minute should be tried. In cases where digitalis is the cause of the ectopic activity, it should be stopped immediately. Potassium supplements may be effective in abolishing the arrhythmia. If not, lidocaine intravenously 1 mg/Kg body weight or propranolol 1 mg intravenously or diphenylhydantoin 100 mg intravenously may be used. As a general rule, when there is underlying heart disease, particularly coronary heart disease, it is prudent to suppress ventricular premature beats as they may lead to ventricular tachycardia or fibrillation.

Ventricular tachycardia (Fig 1F) is a very serious arrhythmia which generally is seen only in patients with heart disease. As is to be expected, it is most commonly observed in coronary heart disease but it also is seen in rheumatic heart disease and on rare occasions in normal individuals. It can also be caused by a variety of drugs of which digitalis is most often incriminated.

While this arrhythmia may be mistaken for atrial tachycardia with aberration, which is a less ominous rhythm disturbance, and one which would be expected to respond to carotid sinus stimulation, treatment should not be delayed in order for an accurate electrocardiographic diagnosis to be established. Ventricular tachycardia is a cardiac emergency and treatment should not be delayed. Immediate use of either DC countershock 50 Watt/seconds or a lidocaine bolus in a dosage of 50 to 100 mg intravenously is indicated. If the arrhythmia is resistant to such measures, although this is not likely, propranolol 1 mg intravenously should be tried or alternatively diphenylhydantoin 100 mg intravenously every five minutes or until 1 gram has been administered. When it is suspected that ventricular tachycardia is due to digitalis, the treatments of choice are intravenous potassium 40 mEq in 500 ml 5% dextrose in water and diphenylhydantoin 100 mg or propranolol 1 mg.

In this brief discussion, an attempt has been made to describe the techniques and drugs most useful for the treatment of the important cardiac rhythm disturbances. It is hoped that it will serve as a guide for the practitioner who has to make the decision as to the course of therapy his patient is to receive. □

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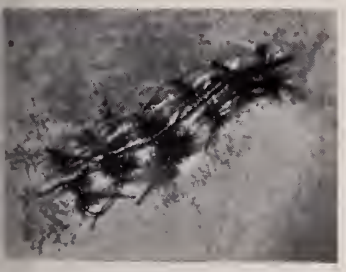

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Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

*Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 7 JULY 1973

FROM THE PRESIDENT

Accountability Is Our Goal

THE GOAL OF PROFESSIONAL updating is to maintain a high level of competence and productivity in physicians to guard against the eroding effects of time and obsolescence.

The State Medical Society of Wisconsin, during its recent meeting, directed the Commission on Scientific Medicine to pursue the role of implementing and coordinating continuing medical education in Wisconsin. This herculean task is presently being studied by this Commission. Few things are more urgent in health care in Wisconsin than the assessment of our continuing educational process which reflects in the quality of medical care given to our citizens. The amount of effort dedicated to this end is great at this time.

The coordination and implementation of all efforts, at all levels—local, regional, and state—is essential. The voices of individual physicians, specialty groups, hospitals, educators and government, must be heard so that our goals will truly represent the fulfillment of our responsibility.

However great the input might be, we must be cognizant that the greatest strength of continuing medical education comes from people at the local level identifying their needs and objectives and selecting programs to fulfill these goals.

The physicians in Wisconsin are aware that the rate of change and the addition of new data and knowledge are accelerating; that continuing medical education becomes essential to keep abreast. The process of updating requires radical changes in educational and professional thinking, not the least of which is the recognition that life-long education must become an integrated part of our professional endeavor.

The important questions of continuing medical education relationships to recertification, professional standards review organizations, and peer review committees, are not clear at this time. These interrelationships must be studied and recommendations must be forthcoming. Any program that stresses increased learning and knowledge, to be effective, must demonstrate that it can be translated into programs assuring better quality of care to our citizens.

The time is now for physicians to demonstrate that they not only can, but are enthusiastic about assuring quality health care. The knowledge that they are doing the best possible job has to be the motivation for continuing education. The very essential feature of quality assurance and continuing medical education is the continuing competence of practitioners, the detection of their deficiencies at the earliest possible moment, and the institution of remedial educational measures as soon as possible. It is through these methods that accountability is measured. Accountability is our goal.

G. J. Devus M.D.

Center Stage: Review Foundations, PSRO

WISCONSIN VIGNETTE FOR 1975: *A teacher enters the hospital because of chest pain. The day following admission, the nurse coordinator reviews the chart and affixes a sticker indicating the expected length of stay (14 days) derived from the norms according to the admitting diagnoses (possible myocardial infarction).*

The nurse coordinator reviews the chart every day. She notes that the tests for myocardial infarction were negative and that a new diagnosis of cholecystitis had been made. She discusses this with the attending physician when he makes rounds and she visits the patient with him. She assists the hospital home health coordinator as extended care arrangements are made prior to the new expected discharge date. On the last hospital day, she fills out a data recording form, later used for an analysis of the quality of care received by the patient. This information is used by physician continuing educational facilities.

If the data clearly fail to fit within the norm guidelines, the nurse coordinator consults with one of the medical advisors. The advisor may, in turn, seek more information from the attending physician.

NOT FANCIFUL, and certainly not impossible. In fact, allowing for variations in detail, this vision of hospital care a few years or so hence is now a reality in some states.

With development of Wisconsin Health Care Review, Inc. (WHCRI), and the passage of last year's Social Security Amendments incorporating the concept of professional standards review organizations (PSROs), this vignette is close to being a certainty.

Since WHCRI was formed by officials of the state medical, dental, and hospital associations in 1971, peer review has come more and more to the center of health-care discussions. This discussion has intensified as the date approaches for PSROs to go into effect.

Although (as reported in the June GREEN SHEET) there is considerable confusion about exactly how a PSRO will be defined and what it will do, WHCRI is moving ahead as the central state agency for professional peer review by the major providers of health-care services. Hopefully, its progress is substantial enough to convince PSRO administrators in Washington that it should indeed be designated the single "umbrella" PSRO organization for Wisconsin.

In a May 23 letter, State Medical Society president, Gerald J. Derus, MD, Madison, asked each member of the Society to study this question and help the county societies take a position on area PSRO designation.

At this point it would be well to take a look at exactly what WHCRI is doing, how far it has come since its birth 18 months ago, and what is planned.

Q. — What Is Wisconsin Health Care Review, Inc.?

A.—It is a not-for-profit corporation formed by the State Medical Society of Wisconsin, Wisconsin Hospital Association, and the Wisconsin Dental Association. Representatives of these three groups, along with four public members, make up its board of directors.

The three incorporating groups joined by seven other health-provider organizations to make up WHCRI's provider advisory panel. Each assists WHCRI in developing review mechanisms and guidelines measuring quality care for their respective disciplines. They are the Wisconsin Optometric Association, Wisconsin Pharmaceutical Association, Wisconsin State Podiatry Society, Wisconsin Chapter American Physical Therapy Association, Inc., Wisconsin Nurses Association, Inc., and Wisconsin Association of Nursing Homes, Inc. The Wisconsin Association of Osteopathic Physicians and Surgeons closely follows all WHCRI meetings and activities. Nationally, osteopaths are seeking to clarify the status of osteopathy under the PSRO law.

WHCRI also has a Consumer Advisory Committee. Two representatives from each of the eight area wide comprehensive health planning districts will be selected by the public members of the WHCRI board to serve on this committee. It will advise the board on special health-delivery problems arising in each locality and will aid in clarifying and defining the various relationships and responsibilities of health-care consumers and providers.

In the formation stage is a Health Insurance Advisory Committee. This would assist WHCRI in the development and implementation of review programs to insure they meet the needs of processing claims under both government and private programs.

Q. — Why Is WHCRI Needed?

A. — The public is very conscious that the cost of health care is rising. The public is also becoming much more concerned about the quality of care being delivered. WHCRI can give visibility about

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

SAMA-MECO

Learn by Observing

For the third year Wisconsin medical students are participating in the Student American Medical Association's (SAMA) summer MECO project. An acronym for Medical Education Community Orientation, MECO places medical students in hospitals in smaller communities to encourage the future physicians to go into practice in these areas.

This year 18 pre-sophomore medical students — 17 from Wisconsin medical schools and one from Northwestern — are participating in the Wisconsin program. Hospitals contribute a $75 a week stipend to each of their students, along with additional contributions for SAMA administrative expenses. A physician from each hospital's medical staff is responsible for direction of the student's activities.

The 10-week program is designed to give the students an introduction to medical care as it is delivered in the hospital and physician's office. This year there is also a special emphasis on health-related community agencies. The idea is to show students how such agencies work and what their function is in health care. □

the quality of care being delivered to efforts in both areas.

Also, the WHCRI system of district review panels offers an efficient, workable mechanism by which to provide greater public accountability for quality and cost, unite medicine and other professions in review programs, and at the same time meet the requirements of the PSRO law for local review.

Q. — What Are WHCRI's Functions?

A. — WHCRI has been designed to act as a monitor of the relationships among patients, health-care providers, and those groups that pay most of the health bills in Wisconsin. As the central health-care data bank, WHCRI will carry out health-care data analysis through a coordinated effort in the collecting of health-care data necessary for the proper evaluation and measurement of provider practices.

Q. — How Does WHCRI Work?

A. — It provides financing, planning, administrative, and data processing services to the district and local review structures through contracts executed with government and the insurance industry.

Actual peer review work is done at the local level by those health-care providers most familiar with the facilities and socio-economic elements of the locality, and the skills and attitudes of their local peers.

WHCRI's medical panel (State Medical Society's Committee on Peer Review) has long functioned as a peer and utilization review mechanism for private insurance carriers, individual citizens, and Medicare matters.

Q. — What Reviews Has WHCRI Done?

A. — In 1972, WHCRI's medical panel planned and completed an on-site independent medical review of some 3,000 patients in the three state colonies: Central Colony, Madison; Northern Colony, Chippewa Falls; and Southern Colony, Union Grove. Local physicians performed the review. The project reviewed patients with care financed under Title XIX (Medicaid) of the Social Security Act. The State Department of Health and Social Services contracted for the review to comply with Social Security Administration regulations.

Now WHCRI, in cooperation with the Division of Family Services of the Department of Health and Social Services, is implementing an Independent Medical Review of Wisconsin nursing home patients whose care is financed by Medicaid. This begins with an independent evaluation of each patient's plan of care. Included in the study are whether the care is appropriate to the patient's medical needs and whether it is being properly implemented. It also evaluates the facility and its staff and considers the suitability of alternative levels of care either in that or some other facility.

Q. — What Exactly Is the Relationship Between WHCRI and PSRO?

A. — The State Medical Society of Wisconsin, through actions of its Council and House of Delegates, has strongly recommended that all citizens, physicians, and other providers of health care, and third party payors will be best served through the designation of WHCRI as a single statewide PSRO.

When the PSRO requirement was enacted into law last year, WHCRI was in the process of studying how to set up its district review panels. Now the existence of PSRO adds another element to the drawing of district lines. One basic part of the district panels will be representation from each local medical society in the area served.

Q. — What Is a District Review Panel?

A. — County medical society representatives from a grouping of counties are responsible for the accomplishment of impartial and objective review throughout the district. It also appears that, under the Medicare-Medicaid programs, fees are increasingly becoming a matter of concern in areas broader than that of local medical society. It seems logical, therefore, that district review may be appropriate for this purpose within the next few years because of the areawide collection of fee statistics under these programs. In cases of fee review requests from insurance companies, WHCRI will continue to utilize county medical societies for such reviews. In the past various county medical societies have played an active part in fee review for government and insurance programs.

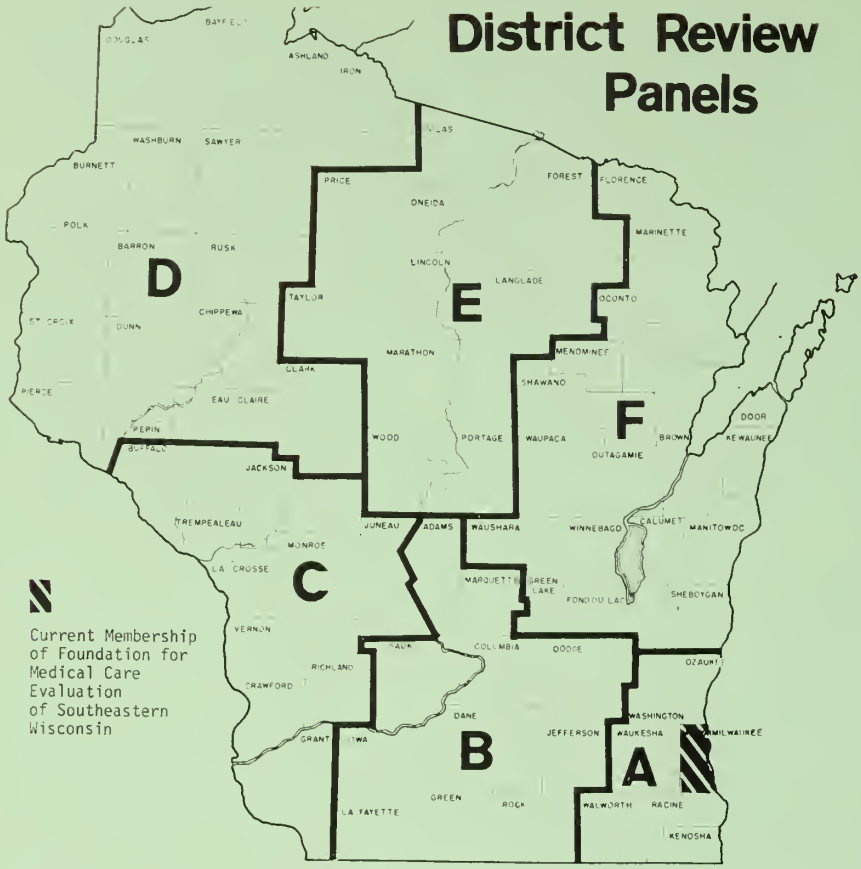
Restored Cannon Placed at Museum

A restored pre-Civil War cannon with a long history in Prairie du Chien was presented to the Museum of Medical Progress there on June 10.

Making the presentation was (right) the Reverend Gregory F. Lucey, president of Campion High School. The school owns the cannon and is placing it on permanent loan at the Museum.

Accepting for the State Medical Society were (left) Drs. L. C. Pomainville, Wisconsin Rapids, Society historian, and Robert T. Cooney, Portage, president of the Society's Charitable, Educational and Scientific Foundation. The Foundation owns and operates the Museum.

The State Medical Society's Academy of Medical History spent two years restoring the cannon. This included construction of the cannon's carriage, following authentic Civil War plans. □



This is the way WHCRI has suggested setting up district review panels for medicine. It has requested that federal PSRO authorities designate WHCRI the administrator of a statewide PSRO, with responsibility for the actual review residing in the six districts shown here.

CENTER STAGE . . .

NOTE: Districts proposed by WHCRI (as shown on the accompanying map) attempt to locate district review panels with numbers of acute-care hospital beds, physicians, skilled nursing homes and beds grouped as equitably as possible.

Q. — Where Do Local Foundations Fit In?

A. — Foundations play an important role, for they would be expected to serve as district or local review agencies to do the actual business of reviewing under the contracts administered by WHCRI.

Q. — What Role Does the County Medical Society Play?

A. — Establishment of district review panels can only be done in concert with the county medical societies involved. On April 30, the Council Committee on Peer Review sent a package of information to each county medical society and specialty society. This included a position paper dealing with the rationale and recommendations for the creation of district review panels in suggested geographic areas of Wisconsin. Each of these societies has been asked to consider and endorse these proposals. Affirmative action from the individual societies will give government an indication of medicine's intent to have a unified and coordinated statewide PSRO approach. □

Stringent Controls Put on Methaqualone, Methadone

Two addictive drugs have been placed under more strict controls by the Wisconsin Controlled Substances Board.

The "Love Drug," methaqualone, has been placed on the schedule of controlled substances. The heroin substitute methadone now is only available under more stringent rules.

Methaqualone—called the "Love Drug" because of supposed aphrodisiac qualities—is a sedative-hypnotic prescription drug. It is dispensed under such trade names as Quaalude, Optimil, Sopor, Parest, Somnafac, and Biphetamine T.

Methaqualone has now been designated a Schedule II substance. This puts it in a class with such drugs as amphetamines, methamphetamines, opium, cocaine, and methadone.

Methaqualone has shown an increasing use among young people and adults as a readily available drug of potential abuse, the board said. The drug was originally thought to be nonaddictive physically, but new evidence has been found to disprove that theory, the board said. In addition, the depressant effect of the so-called "Love Drug" actually decreases sexual capacity.

Persons who illegally manufacture or deliver the new Schedule II substance may be fined up to $15,000 or imprisoned not more than five years or both. Users of the drug who obtain it other than through a prescription may be guilty of a misdemeanor.

This action places Wisconsin with New York in placing more stringent controls on methaqualone. Last month the American Medical Association voiced its support for strict control of the drug through administrative action.

In the case of the restrictions on methadone use, the state board generally followed guidelines established by the FDA on March 15. As of July 1 in Wisconsin methadone is restricted to use as an analgesic for severe pain other than pain of narcotic withdrawal, for detoxification of narcotic dependents, and for treatment of narcotic dependent individuals.

Distribution of the drug in Wisconsin is now more tightly controlled than federal rules require. This includes a residency requirement of 30 days to establish eligibility. Such a rule, according to Attorney General Robert W. Warren, would prevent transient users of the drug to float from state to state without the benefit of a stable treatment program.

Comprehensive records of methadone distribution are now required and hospitals, community pharmacies, and treatment programs may be inspected by federal and state officials. □

WPS®

report

for Wisconsin Physicians

Volume I Number 4

July 1973

HMP Is Still Growing

Health Maintenance Plan (HMP), WPS' new concept in health care financing, continues to grow. As of June 1 some 675 physicians and 19,000 members were enrolled in the Wisconsin experiment in seven counties.

HMP is a group plan which automatically prepays physicians each month for handling the health maintenance of subscribers. Included in the plan are virtually all diagnostic and therapeutic medical procedures performed for the detection or elimination of an illness or disease. The plan pays for primary health care (office calls, laboratory tests, injections, etc.) as well as major medical expenses.

HMP is creating national attention also. Over 100 health insurance plan presidents, physicians and other insurance professionals from across the nation attended a two-day workshop in Chicago on June 7 & 8. The seminar was at the request of the National Association of Blue Shield Plans and the Blue Cross Association, both headquartered in Chicago.

Lawrence Crocker, M.D., president of Dane County Medical Society, participated in the national seminar along with eight WPS staff members. Dr. Crocker told the attending executives, "The physicians of Dane County are happy to take part in this new program of prepaid health care delivery and to help oversee its growth and development. One of the innovative aspects of this program is the 'open panel' approach, where each patient can choose his own physician even though there may be different doctors at different offices for various members of the family." Dr. Crocker continues, "We physicians strongly advocate the practice of preventive medicine and HMP could be a motivator in having patients come to see us much sooner."

The unusual health insurance policy has received a flood of inquiries from across the country. As an example, the Arkansas Blue Cross and Blue Shield group has made three visits to Madison to study the impact of the plan.

After the last visit, a top executive in the Arkansas organization wrote that:

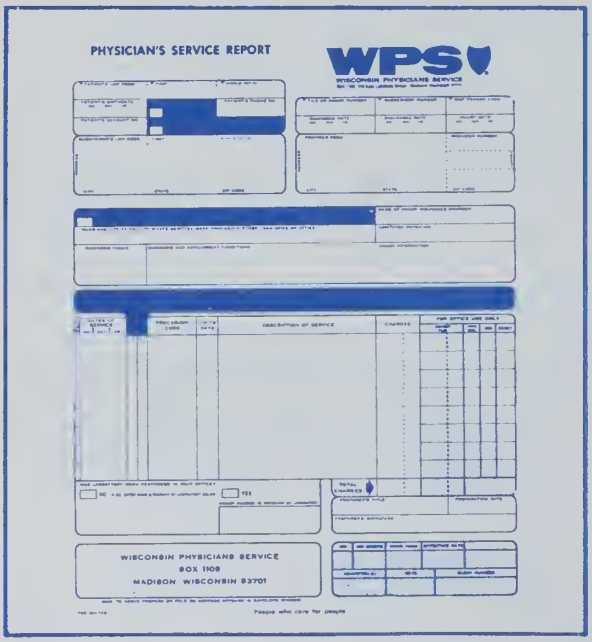
"We left Madison, Wisconsin with a planeload of impressed staff members and Medical Society physicians . . ."

"It was one of the best days I have spent as a grown man," he concluded.

Arkansas is considering launching a similar plan this year.

and their Medical Assistants

New WPS Physician Service Report Form


PHYSICIAN'S SERVICE REPORT

WPS

WISCONSIN PHYSICIANS SERVICE

WISCONSIN PHYSICIANS SERVICE
BOX 1109
MADISON WISCONSIN 53701

The new WPS Blue Shield Physician Service Report, the first new PSR in over 15 years, incorporates several innovations to provide ease of use for you. It makes things easier for you, the provider-typist, for the keypunch operator and the claims adjuster. It is a multi-purpose claim form to ease the paper processing burden in your office.

The new design concentrates on "easy" . . . easy to prepare, easy to read and easy to mail.

The new WPS form incorporates the following features:

- Six tab stops are provided at the top of the form. These tab stops vertically align all typed information.
- A double space setting on the typewriter will align all typed areas horizontally.
- The name and address blocks are located for window envelope use.
- Patient information, subscriber information, physician information, hospital information, diagnosis information and service-charge information are all located in separate blocked-in areas for clarity and simplicity.
- All code areas are shaded for clarity.
- The form is designed to accomodate printing at 10 spaces to the inch.
- The form incorporates the most current service codes.
- The name and address blocks are arranged so they can be typed or rubber stamped with four line addresses and still be centered.

Nationalized Diagnosis and Procedure Code Will Not Solve "All" Problems

Over the past several years, there has been much discussion concerning the use of diagnosis codes and procedure codes in the completion of claim reports. Much emphasis has been placed on nationally recognized codes. If these codes were adopted on a nationwide basis, it would preclude your having to put down any descriptive information relative to the diagnosis or performed procedures.

Even though the various coding systems have merits, they will not solve all our problems. Let's examine the pitfalls of reducing pertinent medical terminology to a code.

At the present time, all major insurance carriers take the descriptive information you have on your claim reports and reduce it to a code for their own internal statistical gathering purposes. The insurance people performing this service go through an intensive training period in order to make sure that the transformation from narrative information to coded information is accurate. Assuming that the physician himself would not be performing this service in your office, it then follows that a lay individual would need to be fully trained to perform this service.

Secondly, there would have to be some type of follow-up auditing in order to assure yourself that certain quality standards are being followed. At WPS between 10% and 15% of the claims processed through the Blue Shield department are reviewed by our Internal Audit Department for accuracy of the benefit adjudication as well as the accuracy of the coding. Would you be in a position to review in your office?

Thirdly, and most important, we have found specific examples, on a follow-up basis, where a code on a claim report did not agree with the operative report. In other words, there can be errors in the doctor's office.

Therefore if WPS did accept coded information on WPS claim reports, without any corroborating narrative information, you should consider the possibility that it might be necessary for us to perform audits at your office.

WPS

MUSEUM EXHIBIT

Supporting Human Life Extraordinarily

A big new exhibit showing the achievements of science and industry in supporting human life in outer space, in the jet stream, and in the ocean depths is now on display at the Museum of Medical Progress in Prairie du Chien.

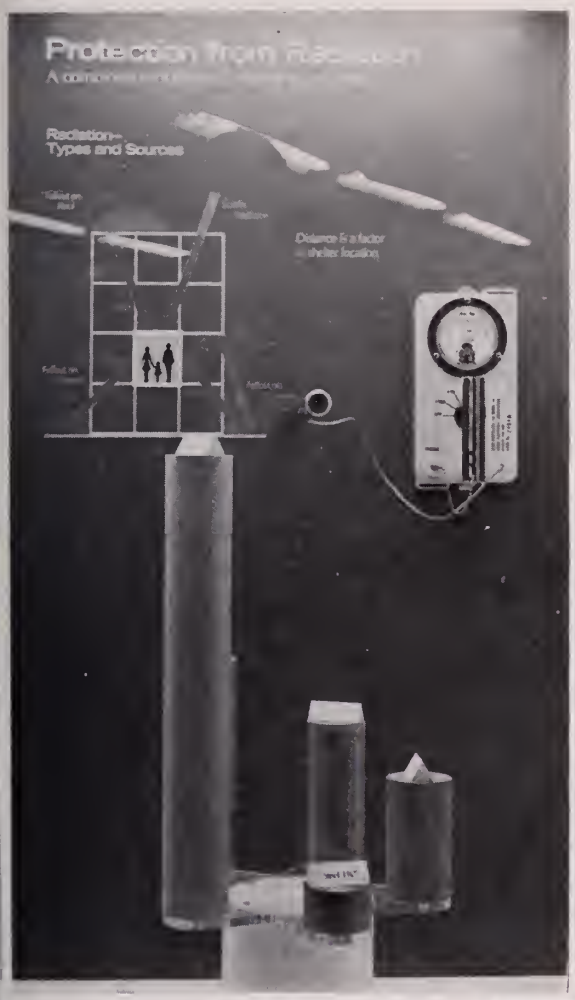
Prepared by the federal Defense Civil Preparedness Agency, the exhibit shows such things as life support systems for outer space travel, how to cope with disasters like floods, hurricanes, and earthquakes, and protection from radioactivity.

The 3,000 square foot display almost totally fills the Stovall Hall of Health at the Museum. However, one of the most popular displays in the Hall of Health is still in place. That is the "Transparent Twins," life-size plastic female models that explain how the body works.

Pioneer medicine displays in the Museum's Fort Crawford Hospital continue to be shown.

Now in its 13th season, the Museum is operated by the State Medical Society's Charitable, Educational and Scientific Foundation.

Museum hours are 8 a.m. to 9 p.m. until Labor Day and then 8 a.m. to 5 p.m. until the season ends October 31. □



Radioactivity protection is another topic explained in the new exhibit, on display until the Museum closes October 31.

This exhibit shows man's creations which enable him to survive space journeys. It is part of "Maintaining Life in a Hostile Environment," now at the Museum of Medical Progress.

NEWS HIGHLIGHTS

Hospitals in Western Wisconsin Form Group

A new group called Shared Health Services Corp. has been formed by 12 general hospitals in the Western Wisconsin Hospital District to promote and coordinate allied health services. It officially began functioning in February.

Gary Qualey, new executive director of the corporation and former administrator of Prairie du Chien Memorial Hospital, said the organization initially will concentrate on group purchasing—buying bulk lots of supplies to get a better price.

Hospitals in the group are: Lutheran and St. Francis in La Crosse, Buffalo Memorial in Mondovi, Prairie du Chien Memorial, Black River Falls Memorial, St. Mary's in Sparta, Tomah Memorial, Osseo Municipal, St. Joseph's in Arcadia, Tri-County Memorial in Whitehall, St. Joseph's in Hillsboro, and Vernon Memorial in Viroqua.

The corporation also will study alternatives in providing and combining services in such areas as accounts receivable, printing and microfilming, and other health services. Administrators from each of the hospitals involved make up the corporation's board of directors.

Three Generations of Stiennon Doctors

With the graduation of O. Arthur Stiennon from the Medical College of Wisconsin, there are now three generations of Stiennon doctors. They are shown above during the Commencement Exercises May 27 in Milwaukee, left to right: Oscar A. Stiennon, MD* of Green Bay (grandfather); O. Arthur Stiennon of Madison (grandson); and O. Arthur Stiennon, Jr.* of Madison (the latter's father). The new graduate will spend his internship (rotating) at Sacred Heart Hospital in Spokane, Wash. Grandfather Stiennon also was honored as one of the alumni cited for fifty years plus service. He graduated in 1918. A general practitioner, he is semi-retired. Father Stiennon is a radiologist in Madison. He graduated in 1943 from the University of Wisconsin Medical School. The new graduate received his BS degree from the University of Wisconsin in 1969. (Photo courtesy of Medical College of Wisconsin Public Information Office)

PHYSICIAN BRIEFS

Robert D. Bush, MD*

. . . Manitowoc, recently was elected president of the Manitowoc County Comprehensive Health Planning Committee. Doctor Bush, pediatrician at the Manitowoc Clinic since 1959, served as a fellow of the AAP and is a member of the City of Manitowoc Board of Health. In March 1968, he was one of the physicians selected by the American Academy of Pediatrics to evaluate the medical aspects of Head Start programs throughout the United States.

Rudolph A. Barta, MD*

. . . Madison pediatrician, recently rejoined MDs A. M. Iams,* C. R. Weatherhogg,* and R. G. Grassy,* pediatricians at the Madison Medical Center. Doctor Barta is a clinical assistant professor in the Department of Pediatrics, University of Wisconsin-Madison Medical Center, and participates in the Newborn Center program of Madison General Hospital and St. Marys Hospital Medical Center. He also is editor of the statewide perinatal newsletter distributed to physicians and nurses specializing in this field.

Roger H. Strube, MD*

. . . Cudahy, has been named medical director of personnel health services at Trinity Memorial Hospital, Cudahy. A member of the active medical staff, Doctor Strube will perform all preemployment physical examinations and review all periodic employee tests as physician-in-charge of employee health services. A native of Bay View, Doctor Strube received his medical degree in 1968 from the Medical College of Wisconsin, then interned at St. Luke's Hospital in Milwaukee, and spent two years in a radiology residency program at St. Luke's. He joined the Trinity medical staff in April 1970.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Clark O. Olsen, MD*

. . . orthopedic surgeon at the Dean Clinic in Madison, spoke on the new methods of treating arthritis surgically when he appeared on the program of a free public forum on Arthritis held April 12 in conjunction with a meeting of the Richland Center Senior Citizens group. The forum was sponsored as a public service by the Southern District of the Arthritis Foundation of Wisconsin.

Otto A. Mortensen, MD*

. . . who last year retired as professor of anatomy at the University of Wisconsin–Madison Medical School after 45 years on the faculty, was presented the Emeritus Faculty Award May 18 during the Medical School's Alumni Day activities in Madison. Doctor Mortensen is the 14th Emeritus Faculty Award recipient and for the past year has been a visiting professor at Stanford University in California.

George Pope, MD

. . . will be joining the associates of the River Falls Medical Clinic in September. Doctor Pope graduated from the University of Minnesota Medical School in 1970 and served his internship at Hennepin County General Hospital, Minneapolis, and was in practice in Cloquet, Minn. He presently is serving in the United States Air Force at Peterson Field, Colorado Springs, and will be discharged in August.

Terrance C. Coyne, MD

. . . will become associated with MDs Richard L. Hartzell* and Alan Hay of the Grantsburg Clinic early in July. Doctor Coyne is a graduate of the University of Wisconsin Medical School and is currently interning at the United States Public Health Service Hospital, New Orleans, La.

Paul R. Bishop, MD*

. . . Prairie du Sac, was a proud father during the recent honors convocation of the University of Wisconsin–Madison. His son, Mark, a senior medical student at the UW–Madison Medical School, was cited for the high degree of concern for patients he served. The award was presented by Associate Dean Richard Hong after selection by a school scholarship and awards committee. The award is particularly significant to the Bishop family and to the Prairie du Sac community because the award honors Gibbs Zauft, MD,* a Prairie du Sac family physician who happens to be the partner of the elder Bishop. Both Doctors Zauft and Bishop are UW Medical School graduates.

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Walter P. Blount, MD*

. . . emeritus clinical professor and former professor and chairman of orthopedic surgery at the Medical College of Wisconsin, Milwaukee, was recipient of the Distinguished Service Award during MCW's commencement exercises May 27. Doctor Blount is perhaps best known for his development of the "Milwaukee Brace" with his long-time colleague, Albert C. Schmidt, MD,* in 1946. It is being used worldwide in the treatment of scoliosis and round back in young children. Doctor Blount joined the Milwaukee Children's Hospital staff in 1929 and later served as its chief of orthopedic services. In 1956 he was appointed clinical professor and chairman of the department of orthopedic surgery at MCW, where he expanded the Milwaukee orthopedic residency program in size and quality. Over a period of nearly half a century he has made many original contributions in his field. Throughout this time, his interest has centered on children's problems. His work on children's fractures is legend. At the age of 75 he continues his consulting practice and has a busy schedule of lecturing and writing.

J. Cyril Peterson, MD*

. . . who is retiring this year as professor and chairman of pediatrics at the Medical College of Wisconsin, Milwaukee, was recipient of the Distinguished Service Award during MCW's commencement exercises May 27. Doctor Peterson, held in high esteem by his colleagues and peers, joined the Medical College in 1953 as professor and chairman of the department of pediatrics. As the first pediatrician-in-chief at the Milwaukee County Hospital he single handedly built a department of pediatrics that has over the last 20 years made significant contributions to the community. Doctor Peterson's research, especially in the area of infectious diseases, has contributed greatly to the prophylactic immunization against infection in early childhood. In the last 10 to 15 years he has functioned mainly as an administrator and teacher. His great warmth, vitality, and love of children have won him the affection and respect of patients, students, and staff alike. Doctor Peterson's plans are to continue to work and serve the community.

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Doctor End

Edgar M. End, MD*

. . . one of the nation's most noted experts in hyperbaric physiology, was honored by the Medical College of Wisconsin, Milwaukee, in May when he was selected to give the first Simon C. Weisfeldt Memorial Lecture. Richard D. Stewart, MD,* chairman of the MCW's Department of Environmental Medicine, said Doctor End was chosen for his work in helium-oxygen diving, saturation (long-term) diving, development of self-contained underwater breathing apparatus, supervision of record deep dives, use of low pressure oxygen in decompression of divers, treatment of carbon monoxide poisoning and explanation of decompression sickness. The lecture, entitled "Recycling Brains—The Hyperbaric Approach," was presented May 18 in Milwaukee County General Hospital. Doctor End is Assistant Clinical Professor of Environmental Medicine at MCW. This annual lectureship of the Department of Environmental Medicine has been established by the family, friends, and associates of the late Simon C. Weisfeldt, MD, to promote education in a field which was of particular concern to this physician whose career was spent in industrial medicine. Doctor Weisfeldt was Chief of Industrial Medicine and co-founder of the Medical Surgical Clinic in Milwaukee and was Medical Director for 163 industrial firms in Milwaukee. He died May 13, 1972, at the age of fifty-nine.

Robert A. Dedmon, MD*

. . . Neenah, recently was elected president of the medical staff at Theda Clark Hospital. MDs Safouh A. Atassi* and Kenneth G. Newby,* were elected vice-president and secretary-treasurer, respectively.

Joseph F. Bachman, MD

. . . Neenah, recently became associated with the medical staff of the Riverside Clinic, Menasha. Doctor Bachman graduated from the University of Michigan School of Medicine and served his internship at Pennsylvania Hospital, Philadelphia, and his residency at Henry Ford Hospital, Detroit. Prior to joining the Riverside Clinic, he was associated with the medical staff at the Scott and White Clinic, Temple, Tex.

Robert C. Feulner, MD*

. . . Waukesha, in May was elected to the board of directors of the Comprehensive Health Planning Agency of Southeastern Wisconsin.

L. O. Simenstad, MD*

. . . Osceola area physician for 49 years, recently was honored by having a new nursing care facility, adjacent to the Osceola Hospital, dedicated to him in recognition of his "devotion to his profession and his genuine interest in the total needs of the community for the past 49 years." The Nursing Care Unit held open house April 29.

Doctor Simenstad also is the village president. He has served his medical profession in a number of significant capacities, the most notable of which are his services as a former AMA trustee, past president of the State Medical Society of Wisconsin, and former member of the Society's Commission on Medical Care Plans, the health insurance division which directs Wisconsin Physicians Service (WPS-Blue Shield). □

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1973

5 Dane County Medical Society Board of Trustees/Public Relations Committee

5 Madison Urological Society

5 Madison General Hospital Surgical Staff

5 Madison Anesthesiology Society

6 Legislative Committee, Wisconsin Association of Professions

7 Evaluation Committee, Wisconsin Emergency Medical Services Program

7 Planning Committee, SMS In-Depth Teaching Program

8 SMS Maternal Mortality Study Committee/SMS Division on Maternal and Child Welfare

12 State Medical Examining Board

13 State Medical Examining Board

14 State Medical Examining Board

14 Executive Committee, SMS Council

14 SMS President's Dinner

15 Medical Advisory Committee, Wisconsin Emergency Medical Services Program

19 Central Committee, Aesculapian Society

19 Board Exams for Internal Medicine

19 Program Committee, SMS Annual Meeting 1974

20 Board Exams for Internal Medicine

20 SMS Commission on Hospital Relations and Medical Education

21 SMS Ad Hoc Committee on Chiropractic

22 Steering Committee and Task Force, Wisconsin Emergency Medical Services Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Wisconsin Neurological Society Elects Officers

At the Spring Meeting of the Wisconsin Neurological Society, held June 1-2 at the Wisconsin Center in Madison, the following officers were elected: president—Keith C. Bogart, MD*, La Crosse; president-elect—Louis J. Ptacek, MD*, Marshfield; vice-president—Gastone G. Celesia, MD*, Madison; and secretary-treasurer—Timothy K. Henke, MD*, La Crosse.

Milwaukee Neuro-Psychiatric Society Elects Officers

At its annual meeting May 23 the Milwaukee Neuro-Psychiatric Society elected the following officers for the ensuing year: president—Joseph E. Weber, MD,* Milwaukee; president-elect—Charles A. Wunsch, MD,* Milwaukee; secretary—Albert Kniaz, MD,* Milwaukee; and treasurer—George E. Currier, MD, Wauwatosa. It also elected the following councilors: MDs Jules D. Levin,* Bernard S. Schaeffer,* and Jack E. Geist,* all of Milwaukee.

Chetek and Barron Medical Clinics Merge Staffs

In early May it was announced that the medical clinics in Chetek and Barron had merged their medical staffs to provide services of eight physicians in those communities on a full-time basis. The merged group is known as the Chetek Medical Clinic, S.C. Besides the four physicians working in Chetek and two in Barron, two additional staff members will be added to the group during the summer, it was reported. The newcomers will be Howard Thalacker, MD, a University of Wisconsin graduate now completing internship at St. Mary's Hospital in Duluth, Minn., and Michael Damroth, MD, a graduate of Northwestern Medical School and now serving in the Army in Rhode Island. Present members of the clinic at Chetek are MDs Joseph Bender, David Pierpont, F. M. Bannister,* and James Esswein.* At Barron are MDs C. J. Strang* and Ralph Whaley.* The doctors have said they plan to maintain a staff of four physicians at each of the Chetek and Barron clinics to provide 24-hour emergency service to both communities. The entire group maintains hospital privileges at both the Rice Lake and Barron hospitals.

New Family Practice Clinic in Madison

Madison's third family practice clinic began operation the first of May on the city's northeast side. It opened under auspices of the Family Practice Program of the University of Wisconsin-Madison Center for Health Sciences. Rudolph Hecht, MD, who has been practicing for 17 years at the small community of La Feria, Tex., heads the staff as a full-time physician. He is aided by a staff of residents who are in a three-year residency program in family medicine at the UW-Madison.

The new clinic, which has a 24-hour emergency service, was made possible through the cooperative efforts of John Renner, MD,* director of the Family Practice Program at the UW-Madison, the Legislature University officials, and St. Marys Hospital Medical Center in Madison.

The first family practice clinic under the UW-Madison Program was started some two years ago at St. Marys Hospital in Madison the second began a year ago in Verona.

The Family Practice Program has 14 residents and 6 faculty members, all physicians. Doctor Renner has said that next year there will be 24 residents, and hopefully 34 by 1975 and 36 the following year.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MAY 17, 1973

NEW MEMBERS

Asiddao, Caridad B., 8700 West Wisconsin Ave., Milwaukee 53226
Gallun, Arthur B., 1225 Lakeside Drive, Elm Grove 53122
Hammer, Edwin J., 703 14th St., Baraboo 53913
Hettler, Gerhard III, Student Health Service, UW Stevens Point, Stevens Point 54481
O'Connell, Richard L., Badger Army Am. Plant, Baraboo 53913
Palaganas, B.C., 2501 Main St., Stevens Point 54481
Varma, Rajiv R., 8700 West Wisconsin Ave., Milwaukee 53226

CHANGE OF ADDRESS

Armstrong, Joshua H., West 8th St., New Richmond 54017
Ayengar, Shanta, Box 57, House Staff Residence, University Hospital Edmonton, Alberta, Canada
Banyai, Andrew L., 330 West Diversey Parkway, Chicago, Ill. 60657
Barber, Jergen L., 401 Windsor Dr., Waukesha 53186
Bauer, W.B.A.J., 113½ E. Miner St., Ladysmith 54848
Cassidy, George E., 3415 Chasm Lane, Manitowoc 54220
Chin, Jorge N., Division of Ophthalmology, University of Kentucky Medical Center, Lexington, Ky. 40506
Chojnacki, Steve L., 2218 South 7th St., Milwaukee 53215
Crawford, Chester W., 704 S. Webster Ave., Green Bay 54301
Curran, William P., 1111 Langlade Rd., Antigo 54409
Dungar, Charles F., P. O. Box 767, Appleton 54911
Edwards, Richard G., 1121 Fond du Lac Ave., Kewaskum 53040
Fischer, Louis C., 2613 Sara Rd., Madison 53711
Forbes, Kenneth A., 2021 South Webster Ave., Green Bay 54301
Frase, Louis H., Route #7, Eau Claire 54701
Friedman, Burton J., 2040 West Wisconsin Ave., #707, Milwaukee 53233
Galasinski, Roman E., 3371 South Princeton Ave., Milwaukee 53215
Gallagher, William B., 815 South 10th St., La Crosse 54601
Gericke, Julius T., Jr., 3750 Rimridge Rd., Eau Claire 54701
Harris, John S., P. O. Box 767, Appleton 54911
Head, Rufus W., 1304 N. W. Townridge, Grants Pass, Ore. 97526
Hill, Nels A., 4032 Mandan Circle, Madison 53711
Hitz, John B., Pine Lake, Hartland 53029
Hodges, Paul C., Jr., P. O. Box 1424, Green Bay 54305
Hyslop, Volney B., 8118 West Oklahoma Ave., Milwaukee 53219
Ihle, Charles V., 605 Walker Ave., Eau Claire 54701
Ivsin, Rostislav, 150 East Dekora Rd., Saukville 53080
Kappus, Harold C., 4126 - 7th St., Kenosha 53140
Keeler, Wiliam H., 11552 North Bobolink Lane, Mequon 53092
Krohn, Robert, P. O. Box 620, Black River Falls 54615

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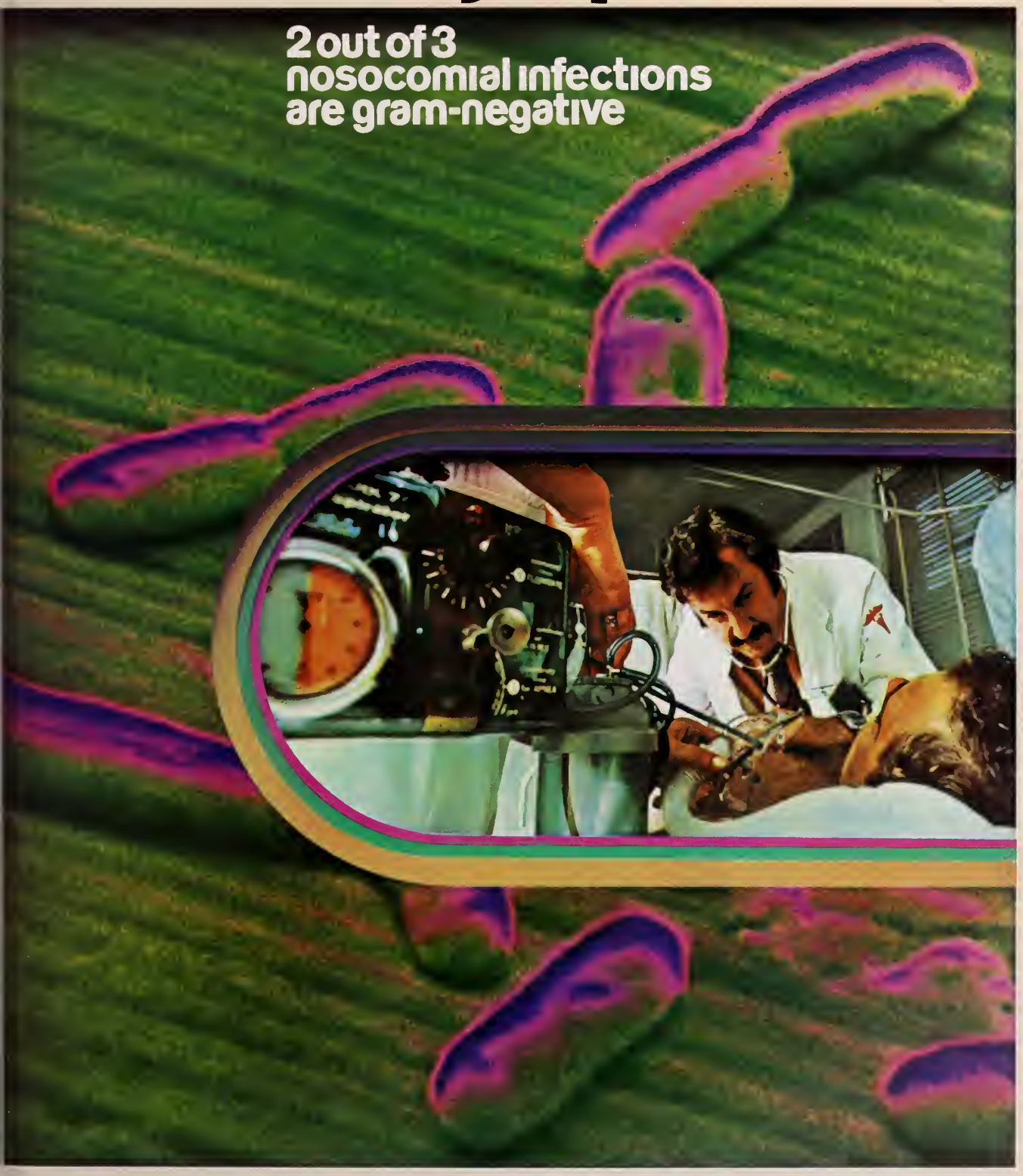
Lane, George H., 1373 West Capitol, Milwaukee 53206
Martens, Jacob H., 400 East Thomas St., Wausau 54401
McNeal, Wesley E., 704 South Webster Ave., Green Bay 54301
Milbrath, John R., 11339 Underwood Court, Wauwatosa 53226
Moermond, James O., Jr., 209 Park St., Antigo 54409
Musgjerd, David G., 2440 Hagen Rd., La Crosse 54601
Neu, Victor F., 2021 South Webster Ave., Green Bay 54301
Petersen, George J., P. O. Box 767, Appleton 54911
Raich, Peter C., 348-N University Hospitals, 1300 University Ave., Madison 53706
Rauch, Alphonsus M., P. O. Box 186, Lake Geneva 53147
Riabov, Sviatoslav N., 1007 North Cass St., Milwaukee 53202
Riese, David C., 1421 - 14th Ave., Monroe 53566
Rosmann, Hermann K., Route 1, Box 188A, Hayward 54843
Rufino, Glicerio L., 1010 Scott St., Kewaunee 54216
Sabado, Ernesto F., 704 Medical Towers, Houston, Tex. 77025
Sablay, Nonito M., 954 Meadow Lane, Fond du Lac 54935
Savage, George W., P. O. Box 767, Appleton 54911
Schalmo, Edwin H., Jr., R R #1, Box 57-A, Mukwanago 53149
Scherping, Walter H., 1021 Lincoln Blvd., Manitowoc 54220
Schmidt, Lou R., P. O. Box 250, Sparta 54656
Selle, Frederick S., 1425 A North 65th St., Wauwatosa 53213
Seno, Elvira C., Route 4, Box 202, Burlington 53105
Shafi, Mohammad, 606 West Wisconsin Ave., Milwaukee 53233
Shinners, George M., 217 - 13th Ave., Green Bay 54303
Sickels, William F., 532 Chatham Court, Neenah 54956
Sinense, Ricardo R., 7229 West Center St., Milwaukee 53210
Sisk, James A., Route 3, 142 Reilly Dr., Fond du Lac 54935
Skemp, Charles A., 815 South 10th St., La Crosse 54601
Skemp, John T., 815 South 10th St., La Crosse 54601
Smith, Charles C., 2021 South Webster Ave., Green Bay 54301
Spring, Donald A., 2040 West Wisconsin Ave., Milwaukee 53233
Stein, Ronald W., W272 N2141 Fieldhack Dr., Pewaukee 53072
Strube, Roger H., 4775 South Packard Ave., Cudahy 53110
Thearle, Daniel S., 361 West Briar Lane, Green Bay 54301
Troup, Charles W., 2021 South Webster Ave., Green Bay 54301
Troup, Richard H., 2021 South Webster Ave., Green Bay 54301
Walsh, Thomas W., 115 Phillips Blvd., Sauk City 53583
Walton, William B., 2550 West Kenboern Dr., Milwaukee 53209
Wells, Marvin, 945 N. 12th St., Milwaukee 53233
Wolter, Serenus H., 8848 Ravenswood Circle, Wauwatosa 53226
Wood, Cordelle A., 315 East Wabash, Waukesha 53186

DEATHS

Henske, William C., Chippewa County, Mar. 25, 1973
Hadley, John O., nonmember, Apr. 4, 1973
Konz, Stephan A., Outagamie County, Apr. 16, 1973
LaBreche, John J., Chippewa County, Apr. 18, 1973
Bachhuber, Alphons E., Outagamie County, Apr. 23, 1973
Baldwin, Elizabeth, nonmember, Apr. 23, 1973
Wiswell, Clifford Y., Walworth County, Apr. 28, 1973
Crigler, Russell R., Milwaukee County, May 5, 1973
Wall, Charles E., Manitowoc County, May 5, 1973 □

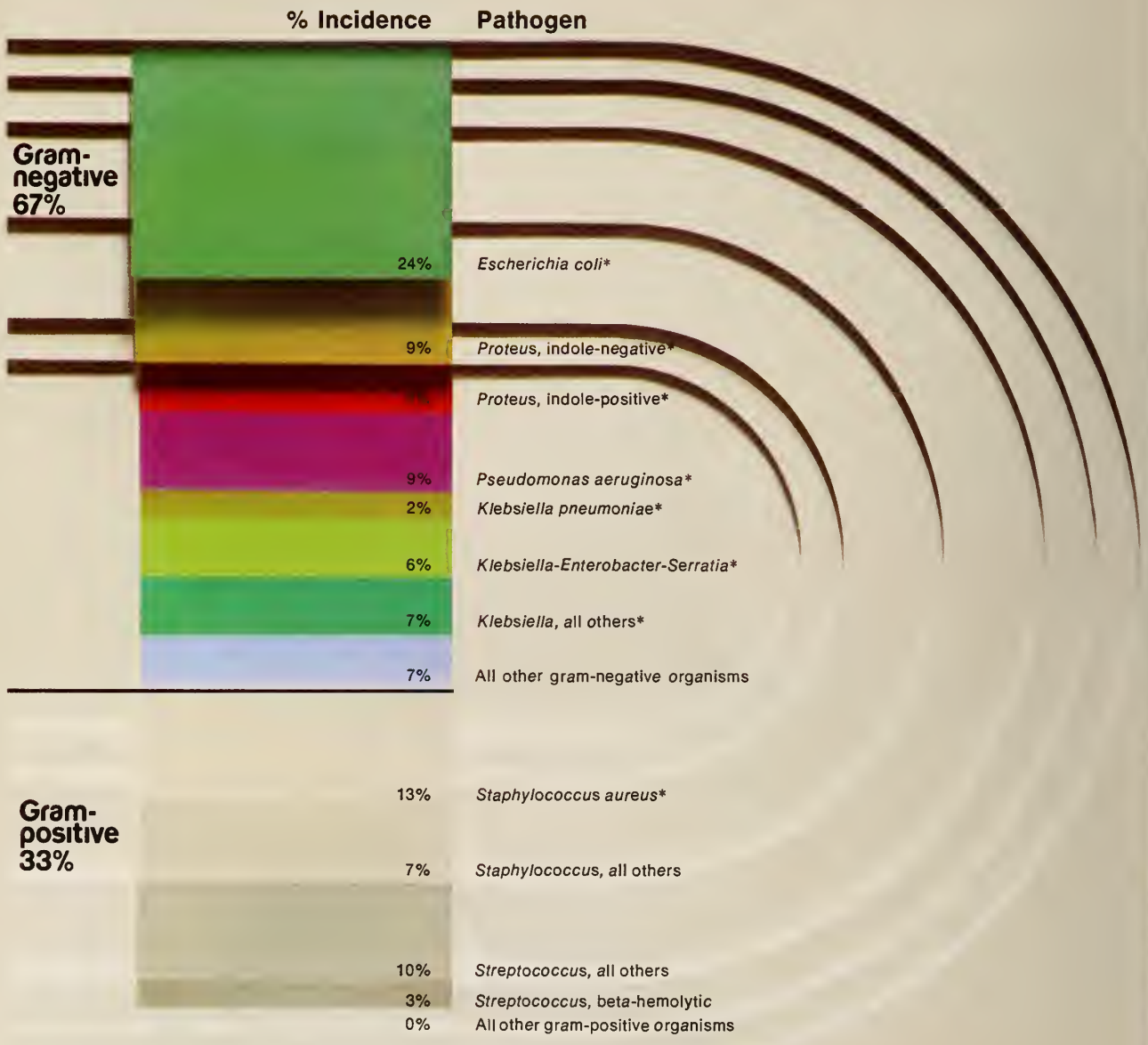
Schering

On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective agains susceptible strains of the pathogens indicatec

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GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

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Proteus, indole-negative
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Pseudomonas aeruginosa
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GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*
*Due to susceptible organisms

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■ **Broad gram-negative spectrum**
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Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

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40 mg. per cc.
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Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

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USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

*Due to susceptible organisms

SLR-301

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, and MISCELLANEOUS. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. BOXED AD RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the first of the month preceding month of issue; e.g., copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING: MULTIspecialty clinic in northwestern Wisconsin is expanding; group seeking

1. Internist
2. General Surgeon
3. Allergist

Ultramodern 500-bed hospital located close to clinic. Excellent recreational area. Salary first year, corporate member thereafter. Young group, incorporated, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 396 in care of the Journal. 6tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

INTERNIST NEEDED: BOARD certified or eligible. Join internist, radiologist, general surgeon, and EENT physician (all certified with another internist joining soon). Modern clinic building in university city. Population 100,000 with 3 fully equipped hospitals. Partnership opportunity after 3 years. J. B. Grace, MD, Green Bay Clinic, Ltd., 123 N. Military Ave., Green Bay, Wis. 54303. 6–8/73

WANTED: YOUNG BOARD CERtified or board eligible Obstetrician and Gynecologist to join three-man group which is part of a multi-specialty partnership (40 physicians) in a rural Midwest community serving an area of approximately 250,000. Contact Dept. 394 in care of the Journal. 5–10/73

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTITIONER to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $30,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

EXCELLENT OPPORTUNITY: General practitioner needed in established practice. Modern clinic adjacent to 85-bed hospital. Progressive community of 6800, excellent schools and recreational facilities. Starting salary $32,000, partnership after first year. Phone, visit or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372–4177. p4-9/73

THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine–multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Psychiatry
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 6–8/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545; tel: 1–608/752–7811. 4tfn

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Dermatology
3. General Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 7-12/73

KROHN CLINIC, LTD., NEEDS physician in rural family practice. Group practice circumstances excellent but must be in early 30s or less. Please contact William B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams Street, Black River Falls, Wis. or phone collect 715/284-4311. 7tfn/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY OR GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months. Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

EMERGENCY DEPARTMENT physician to join three (3) other physicians presently serving a 350-bed community hospital, located in a midwest city of 60,000 with outstanding living, recreational, and cultural facilities. Forty-hour week with competitive salary and benefits. Full specialty backup. Contact: D. E. Kershaw, St. Francis Hospital, 709 S. 10th St., La Crosse, Wis. 54601. Tel: 608/782-8022. 5-7/73

DIRECTOR of MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employe fringe benefit program and salary. Send vita to:

EDWIN A. MUNDY,
DIRECTOR
Institutions & Departments
8731 Watertown Plank Rd.
Milwaukee, Wis. 53226

IMMEDIATE OPENINGS FOR physicians in OB-GYN specialty to establish a successful practice in a multispecialty clinic located close to hospitals. In-clinic medical student teaching opportunity. University and college city. Year around indoor and outdoor family activities of all types. Salary plus excellent benefits first year and corporate member thereafter. Interview expenses paid. Call collect to D. W. Shea, MD, Beaumont Clinic, Ltd., 1821 S. Webster Ave., Green Bay, Wis. 54301. p5-9/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468-2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3-8/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339-3326. 6tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637-9271. 4tfn

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

IMMEDIATE OPENING FOR INternist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB-GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

IMMEDIATE OPENING FOR A family practice physician, and an internist to join 12-man group. New clinic building. University city. One hour from St. Paul. Summer and winter recreation unlimited. Will finance travel for interview. Call or write D. Hilton, MD, President, or Russel Peterson, Business Mgr., P. O. Box 337, Menomonie, Wis. 54751. Tel: 715/235-9671. 6tfn/73

WANTED: PHYSICIANS, SPECIALists or Generalists, who want to practice medicine in a semi-rural area but still have the advantages of the state's largest cultural, population, and medical center within twenty-five minutes travel.

Discover Ozaukee County. A beautiful blend of a rural agricultural setting interspersed with growing communities which are progressive but still preserve the charm and beauty of early Wisconsin history.

Physicians are urgently needed to provide the key that will open the health-care door for the 55,000 people who call this county their home. These people are more affluent than the average in Wisconsin. They need and want physicians to enjoy living and working in this area with all its advantages.

This is a prime recreation area on the shores of Lake Michigan, just north of the hustle and bustle of Milwaukee.

St. Alphonsus Hospital in Port Washington is an orderly, modern facility ready to provide acute, general hospital care in the heart of this county community. It is ideally located in the center of Ozaukee County about 20 miles from other hospitals to the north, south, and west. A new, 12-man office building connected to the hospital will be ready by August 1, 1973, and other office space is available in most of the nearby cities and villages.

If you are interested in the good life, and a good practice, contact George Seidenstricker at St. Alphonsus Hospital, 743 N. Montgomery Street, Port Washington, Wis. 53074. Tel: 414/284-5511. 6-10/73

GENERAL PRACTITIONER wanted to share the good life in beautiful KEWAUNEE, Wis. We can offer you, an accredited hospital, office and clinic space, crime free community, good schools, three fine churches, beautiful homes, beautiful people, Lake Michigan with its fabulous trout fishing, water skiing, boating, snowmobiling, skiing, golfing and the PACKERS. Packer Country is just 25 miles west and lastly—MONEY. Per capita income is high. We see our doctor and we pay our bills. Write to: Doctor Search Committee, P. O. Box 222, Kewaunee, Wis. 54216. 3tfn/73

GENERAL PRACTITIONER needed in growing practice at new 2-doctor clinic, Mosinee, a central Wisconsin progressive industrial-agricultural com-

munity with trade area of 9,000 people. Excellent hospitals nearby. Best of schools, choice of churches, airport jet service. Contact L. J. Akey, Mosinee Community Medical Center, Inc., Mosinee Commercial Bank, Mosinee, Wis. 54455. Tel: 715/693-3021. This ad endorsed by present doctor. 2-7/73

WELL TRAINED PATHOLOGIST, AP (CP eligible), excellent references, special training in oncologic pathology. military service completed, seeks position as associate pathologist or as director. Contact Dept. 393 in care of the Journal. 4tfn/73

THE MONROE CLINIC IS INTERviewing Surgical Specialists to join the present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Surgical Specialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 8tfn

THE MONROE CLINIC IS INTERviewing Medical Specialists to join their present 38 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical Specialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 8tfn

PRACTICES AVAILABLE

GENERAL PRACTICE FOR SALE in population area of 50,000. Over 30 years of established practice. Excellent hospital facilities, fully equipped office. Located in excellent hunting, fishing area. Contact A. A. Muchin, 1004 Washington St., Manitowoc, Wis. 54220. 7/73

GP NEEDED TO REPLACE DEceased MD in established practice. Entire inventory for sale, excellent hospital facilities, good school in resort and recreational area. SE Wisconsin. Contact Box 457, Williams Bay, Wis. 53191. g6tfn/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

MEDICAL FACILITIES

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn

EXCELLENT OPPORTUNITY FOR pediatricians and internists to establish practice in beautiful new physicians condominium building adjacent to Bellin and St. Vincent hospitals in Green Bay, Wis. Patients immediately available on referral from other physicians in the building. Call or write H.F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE NEED CONTINUES!! EVEN though a number of excellent physicians has come to practice in our community, *we need more doctors* . . . particularly family practitioners, internists, orthopedists, otolaryngologists, and ophthalmologists. Join others in discovering Watertown, Wisconsin. New Health Care Center includes 100-bed general hospital, connecting (but separate) medical office building, and connecting 120-bed nursing home.

Progressive and growing community. Good location between Milwaukee and Madison. Medical practice area includes 40,000 people. Good schools. Beautiful parks, trees and lakes. Stable economy.

Medical staff supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wisconsin 53094; tel. 414/261-4210. 7-9/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748-3636. g4tfn/73

FOR SALE: MEDICAL BUILDING. 2100 square feet. Two divided suites. Separate, central gas heat and air conditioning. Paved parking lot. Excellent location. Residential area. Five minutes from either hospital. Contact George Hill Newell, Washington Avenue Medical Building, Racine, Wis. Tel: 414/634-6833. 3tfn/73

FOR SALE: THE LATE DOCTOR Parish's office and waiting room equipment including examining table, equipment for eye testing, two typewriters, medical instruments, etc. Contact Mrs. G. A. Parish, 511 Janssen Ave., Mayville, Wis. 53050. g12tfn

MISCELLANEOUS

GUIDELINES FOR BLOOD-ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

WANTED: USED MICROSCOPES. Nicaragua/Wisconsin Partners of the Alliance have requests for used microscopes suitable for use in Nicaraguan high schools for teaching purposes. Donations to the Partners are tax deductible. Please notify Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701, if you have a usable microscope. g5tfn

PUBLICATIONS

Hospital Adaptation of ICDA (H-ICDA), second edition, will be published in October, ready for use in 1974. Used for coding more patients in U.S. short-term general hospitals than any other classification, it is published by the Commission on Professional and Hospital Activities. In keeping with the pace of expansion of medical knowledge, the second edition can classify and code observations in primary care encounters and ambulatory practice as well as accommodate the needs of the problem-oriented medical record. In addition to hospitals, soon-to-be established PSROs and medical care delivery systems such as HMOs will find the second edition a valuable source. New edition introduces changes which reflect the current interests and concepts of clinical medicine but maintains comparability between the old and new classifications. Published with the encouragement and assistance of advisory committees appointed by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American College of Surgeons, and the Society of Teachers of Family Medicine. Two volumes. In addition to the tabular listings of diagnoses and operations, an alphabetical index will list all diagnoses and operations with their H-ICDA code numbers. Inquiries: CPHA, 1968 Green Road, Ann Arbor, Mich. 48105. 7/73

Guide for School Health Examinations. 40-page, 1970 revised edition, prepared and published by the State Medical Society's Division on School Health in cooperation with the Wisconsin State School Health Council, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, at cost of $1.00 per copy to be sent with order.

Wisconsin Week-End. A charming little publication filled with original and informed writing about fascinating byways, historic sites, events, sports, recreational and cultural activities, museums, shops, art fairs and out-of-the-way places throughout the State. Unrivaled prescription for ennui, valuable aid to the short-trip motorist, delightful addition to your personal library or waiting room. Published 26 times yearly. Winner State Historical Society Award of Merit. Only $4 a year in Wisconsin. Wisconsin Week-End, Spring Green, Wis. 53588. 6/73

ANNOUNCEMENTS

THE CONTROLLED SUBSTANCES Board of Wisconsin will host a one-day, technical symposium on narcotic antagonists on Friday, October 12, 1973. Nationally-known speakers will discuss diagnostic and therapeutic uses, progress in research, clinical experiences and federal and legal outlooks. The symposium will be held at Mendota State Hospital, Madison, Wisconsin. The cost will be $5, which will cover registration, lunch and a copy of the proceedings. Interested parties should contact Ms. Nancy Kaufman, RN, Room 523, 1 West Wilson Street, Madison, Wisconsin 53702 for further information. Registration forms will be available in early August. 7/73

COMPUTERIZED LITERATURE SEARCHES

IN

Index Medicus

NOW AVAILABLE FROM

MIDDLETON MEDICAL LIBRARY

Middleton Medical Library, University of Wisconsin, Madison, is now offering MEDLINE service free of charge to any resident of Wisconsin. MEDLINE is a computerized on-line bibliographic searching capability of the medical literature in *Index Medicus*, developed by the National Library of Medicine. Eventually, there will be a network of about 150 institutional users with individual terminals linked to the data base in Bethesda, Maryland, by long-distance telephone lines. Presently, Middleton Medical Library is the only library in the state offering this service.

Citations stored in the data base cover the period January 1969 to the present and may be retrieved by subject, author, journal, language, and date of publication.

For further information contact

Medical Library Service
Room 202
Middleton Medical Library
1305 Linden Drive
Madison, Wisconsin 53706

Or call collect (608) 262-6524

AMERICAN BOARD OF FAMILY PRACTICE announces that it will give its next two-day written certification examination on October 20–21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. *Please note:* It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *August 1, 1973.*

WISCONSIN PROFESSIONAL SOCIETY ON ADDICTIONS. Membership in the Wisconsin Professional Society on Addictions is open to those who are in a position of directing, administering or coordinating councils, information and referral centers, clinical settings for alcoholism or drug abuse or their divisions who have submitted a written application for membership. Membership fee is $10 annually. Applications should be sent to: William Roberts, 4200 Marquette Drive, Racine, membership chairman. John W. Sell is president of the society whose primary purpose is "to foster coordination, insure cohesiveness and upgrade effectiveness within the information–referral centers throughout the state."

INTERESTED SMS MEMBERS may obtain from the AMA a copy of a new, 185-page AMA paperback which consists of brief information on approximately 200 medical topics, plus references to AMA activities, policies and publications in each field. Send $1 per copy to AMA, 535 N. Dearborn St., Chicago, Ill. 60610. The reference book is available at 50¢ to medical students, interns, and residents. 4/73

ALL PSYCHIATRISTS WHO HAVE not already taken the Psychiatric Knowledge and Skills Self-Assessment Program (PKSAP), are urged to apply for it by writing to the APA, 1700 18th Street N.W., Washington, D.C. 20009. The test stresses patient management problems, allows participants to score themselves in relation to peers, and earns credits for continuing medical education. 4/73

FILMS

Date with Disaster. A 16-mm Kodachrome, 30-minute sound documentary/training film produced by the President's Office of Emergency Preparedness. Available on a free loan basis or may be purchased for $90.

Film documents the multi-hospital preparedness model developed by the Hospital Council of Southern California. This 118 hospital system, linked by a radio network, made the difference between chaos and an orderly medical response in the February 9, 1971, earthquake in San Fernando Valley, California. Film is intended to be a training model for communities across the nation to help them build their own emergency medical preparedness capability.

All those appearing in the film, including narrator Jack Webb, contributed their services as a community benefit project.

Further info: Mr. William Gallagher, Chief, Film Distribution Branch, National Audiovisual Center, General Services Administration, Washington, D.C. 20409, or telephone him on AC 301/763-7786. 7/73

The Edge. The MEDIHC (Military Experience Directed Into Health Careers) Program has announced a new, 20 minute, 16mm color film entitled "The Edge." Filmed at hospitals and health facilities in Missouri, actual employers present their views on utilizing medically trained and experienced veterans in their facilities. It's available on loan, or Mr. Piernot, MEDIHC Coordinator, will present the film to you or to a gathering of your associates. Send inquiries to MEDIHC, Wisconsin Health Council, Inc., Box 1109, Madison, Wis. 53701.

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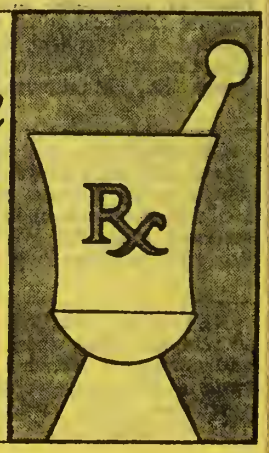

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Sept. 8–9: Wisconsin Allergy Society meeting.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists. Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Sept. 14–15: Wisconsin Surgical Society Fall Meeting, Gateway Resort, Land O'Lakes.

Sept. 21–23: Wisconsin Radiological Society meeting, Sheraton Motor Inn, Madison.

Sept. 22: Second Annual North Central Clinical Cancer Conference, sponsored by the American Cancer Society, Marshfield Clinic, and Clinic Foundation, at University of Wisconsin-Marshfield/Wood County campus, Marshfield. Meeting will focus on the problem of lung cancer.

Oct. 2–5: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison (tentative).

Oct. 6: 18th Annual Fall Physicians Conference (Cancer Scrimmage) from 9 am to 12 noon at University of Wisconson-Madison Medical Center. SMI Bldg, Room 227. Sponsored by the American Cancer Society, UW Department of Continuing Medical Education, and the Division of Clinical Oncology.

Oct. 6: Wisconsin Society of Pathologists meeting, Bellin Memorial Hospital, Green Bay.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

1973 NEIGHBORING STATES

Aug. 18-21: 39th Annual Meeting, American College of Hospital Administrators, Conrad Hilton Hotel, Chicago, Ill.

Sept. 15–16: Seminar on "Management of Sexual and Marital Inadequacy," sponsored by the Institute for Comprehensive Medicine, at Chicago Sheraton Hotel, Chicago, Ill. (Same program will be held Sept. 19–20 at Regency Hotel, Atlanta, Ga., and Sept. 22–23 at Royal Sonesta Hotel, New Orleans, La.) Info: William S. Kroger, MD, 9735 Wilshire Blvd., Beverly Hills, CA 90212.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15-19: 59th Annual Clinical Congress, American College of Surgeons, Chicago, Ill.

Oct. 20–26: Annual Otolaryngologic Assembly of 1973, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

1973 OTHERS

Aug 2–4: Fifth Aspen Conference for Dermatologists, Rocky Mountain Dermatological Society and University of Colorado School of Medicine, The Given Institute of Pathobiology, Aspen, Colo.

Aug. 16-17: Gynecology Course, University of Colorado School of Medicine, Denver, Colo.

Aug. 28–31: 70th Annual Meeting, Wyoming State Medical Society, at Jackson Lake Lodge in Grand Teton National Park, Wyoming.

Sept. 7-8: Conference on "Going Metric: Meeting the Conversion Challenge," cosponsored by University of California at Los Angeles Extension's Department of Continuing Education in Engineering and Mathematics and others, on the UCLA campus.

Sept. 19–22: District V, American College of Ob–Gyn, Pantland Hotel, Grand Rapids, Mich.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Sept. 29: First Invitational Symposium on the Sero-Diagnosis of Cancer, cosponsored by the Laboratory Service, Naval Hospital, Bethesda, the College of American Pathologists (CAP), the American Society of Clinical Pathologists (ASCP), and the Armed Forces Radiobiology Research Institute (AFRRI), in the Naval Hospital Auditorium, National Naval Medical Center, Bethesda, Md. 20014.

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 7-Nov. 2: The Advanced Management Program in Health Care Administration, at University of Pennsylvania, Philadelphia, Pa., sponsored by The Leonard Davis Institute of Health Economics of the Wharton School.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov. 8–10: Third National Conference of the Society for Computer Medicine, Denver, Colo. Info: Joseph M. Edelman, MD, President, Society for Computer Medicine, 200 Professional Center, 244 Peachtree Blvd., Baton Rouge, La. 70806.

Nov 29–Dec 1: National Conference on Virology and Immunology in Human Cancer, Waldorf–Astoria Hotel, New York, N. Y. Sponsored by American Cancer Society and National Cancer Institute.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Jan. 26–27: Council Meeting, State Medical Society of Wisconsin, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

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MEDICAL MEETINGS . . .

1974 NEIGHBORING

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Jan. 2–5: Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, sponsored by the Division of Pediatric Nephrology, Department of Pediatrics, University of Miami School of Medicine, at Eden Roc Hotel, Miami Beach, Fla. Info: Div. of Continuing Education, UofM School of Medicine, P. O. Box 875 Biscayne Annex, Miami, Fla. 33152 (Tel. 305/350–6716).

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

Sept. 1–7: VII World Congress of Cardiology, Buenos Aires, Argentina. Info: American Heart Association, 44 East 23rd St., New York, NY 10010.

Sept. 1-7: VII World Congress of Cardiology, sponsored by the American Heart Association, Buenos Aires, Argentina. A South American Extension Tour to Brazil, Argentina, and Peru arranged through McGuire Enterprises.

Oct. 21–25: Clinical Congress, American College of Surgeons, Miami Beach, Fla.

* * *

Second Annual Course on Fetus and Newborn in High-risk Pregnancy. The University of Wisconsin Center for Health Sciences-Madison and the Wisconsin Perinatal Center-Southcentral Region will present a postgraduate conference on the Fetus and Newborn in High-risk Pregnancy. This course will be held at Madison General Hospital on September 21 and 22. Course is again open to 200 registrants (physicians and nurses) who are interested in acquiring some newer concepts and approaches to assessing the fetus and neonate of specific high-risk pregnancies.

Guest faculty includes Dr. Watson A. Bowes, Associate Professor of Obstetrics and Gynecology, University of Colorado Medical School and Dr. L. Joseph Butterfield, Director, Newborn Center of The Children's Hospital, Denver, Colorado. Twenty-five members of the University of Wisconsin Perinatal Faculty also will actively participate in this program.

The course will consist of formal presentations, panel discussions, three separate obstetric and neonatal workshop sessions, and question-answer periods. Many topics will be covered including Management of Premature Labor, Amniotic Fluid Analysis for Fetal Maturity, Induction of Fetal Lung Maturity, and Intensive Care of the Premature Newborn. Maternal and fetal-neonatal risks of Group B streptococcal infections will be discussed by a panel. Workshop sessions will be available to discuss such problems as fetal monitoring (antepartum and intrapartum), nutrition in pregnancy, management of premature rupture of membranes, neonatal surgical problems, cardiovascular problems of the newborn, and maternal-infant relationships in the newborn period. A panel will discuss practical aspects of sexuality.

For further information and a complete program, write Dr. R. A. Barta, Fall Perinatal Course, 202 S. Park St., Madison, Wis. 53715. A printed brochure will be available soon. There will be a reduced fee for nurse-physician teams. Two hundred reserved seats for the Colorado-Wisconsin football game also will be available through this reservation.

Institute for Comprehensive Medicine is sponsoring two-day seminars on "Management of Sexual and Marital Inadequacy" to be held September 15–16 Chicago Sheraton Hotel, Chicago; September 19–20, Regency Hotel, Atlanta and September 22–23, Royal Sonesta Hotel, New Orleans, for physicians, psychologists, residents, interns and nurses An interdisciplinary approach for the management of sexual dysfunctions will be discussed.

Topics covered will include: Psychology and Physiology of Sexual Response; Adolescent and Geriatric Sexual Problems; Behavior Modification; Biofeedback Control Therapy in Sexual Inadequacy; Compatible Divorce; Transsexualism; Sexual Variants and Fetishisms; Urologic Disorders; Management of Effective Orgasmic Response, and other subjects.

This continuing medical education course is acceptable for 20 credit hours in Category 2 for the Physician's Recognition Award of the American Medical Association.

For further information write: William S. Kroger, MD, 9735 Wilshire Boulevard, Beverly Hills, CA 90212.

The Advanced Management Program in Health Care Administration, October 7 through November 2, will be held at the University of Pennsylvania in Philadelphia. The Leonard Davis Institute of Health Economics of the Wharton School is sponsoring the four-week program which will cover current problems and trends in health care, new management techniques, and their application in the health-care field.

Program is designed for top-level executives and other professionals in health-service organizations including hospitals and nursing homes; group practices; health insurance companies and Blue Cross/Blue Shield; governmental agencies; medical, dental and nursing schools; professional organizations; pharmaceutical firms; large purchasers or users of health insurance—employers and unions.

Limited to 30 enrollees; cost $2,100 covering instruction, room and board, books, social and athletic activities. Application and descriptive booklet from: Mrs. Sue Moyerman, Leonard Davis Institute of Health Economics, 3641 Locust Walk, Philadelphia, Pa. 19174.

VII World Congress of Cardiology, Sept. 1-7, 1974, Buenos Aires, Argentina, sponsored by the American Heart Association, is included in a South American Extension Tour of 17 days in Brazil, Argentina, and Peru, arranged by Thomas McGuire Enterprises, 605 East Algonquin Road-Arlington Heights, Ill. 60005.

This meeting, held every four years, brings together scientists from all parts of the world for a week of intensive exchange of information on advances in the cardiovascular diseases.

Further info: American Heart Association, Inc., 44 East 23rd St., New York, NY 10010. □

Wisconsin Association of Professions, Inc.

1973 CONGRESS

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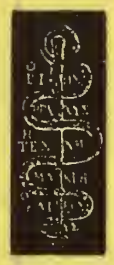

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May 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1973:

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472 SMS members voluntary contributions

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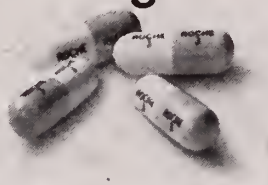

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Contraindications: Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.
Warnings: Use during pregnancy is to be avoided.
Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indiff ent to the economic consequence their decisions." So stated a recen issue of *Medical News Report* (De cember 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasir game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated crease in Blue Shield rates, Dr. Bl ingame's newsletter had this to sa

"In general, it can be said, M have given the impression they ar not particularly concerned with th increase in cost of health care to t patients...

"True, an MD's training is pr marily scientific, but in the real wo of practice, all of his scientific dec sions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attentior Concern for economics of medicir

When the pharmacist recom mends that a drug product other t the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is ne sary for the prescriber to know tha the change is being contemplated and to be in a position to consent c demur. Without that opportunity, t unilateral decision of the pharmac made in the absence of clinical kn edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument t offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowle about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some deg puts him at a disadvantage. Most often, a practicing physician will n expert knowledge of no more than 5

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hould be an obligation of medical ractice...

"Medical societies ought to con- uct continuing campaigns to point ut the substantial savings that could e realized thru deductible insurance nd protection for catastrophic ill- ess. At the very least, they should, in ne patients' interest, question the actics of any insurance organization nat raises health care costs by forc- ng policyholders to buy insurance ney may not need or want and prob- bly won't ever use.

"Too many doctors are indiffer- nt to the economic consequences of neir decisions. Too many, for ex- mple, habitually hospitalize patients or the convenience of the MD. It's onsense to deny such habits exist...

"Doctors, thru their medical so- ieties, have unhesitatingly appealed o their patients for support in the ight against government interference vith the private practice of medicine. and the public in the past has re- ponded. It's time the American Med- cal Association and state and local nedical societies paid off the debt by lecisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the najority of conditions encountered in his practice. Moreover, the physi- cian's choice of a specific brand is based on his knowledge of the pa- ient's medical history and current condition, and his experiences with he particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party ransaction between the pharmacist and the patient, and that a substitut- ng pharmacist may avoid even a echnical breach of contract by simply notifying the patient that he is making he substitution. I would judge that ew courts would be sympathetic oward a pharmacist who substituted vithout physician approval and who undertook a legal defense that seeks o make the patient responsible for he pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and par- icularly the consumer activist, that reduced prescription prices could ollow legalization of substitution. We have seen absolutely no evidence o justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Logic – and a few other things

SOME YEARS AGO a good friend of mine, a dentist in the full-time United States Public Health Service, came to see me, full of anxiety, concern, and genuine puzzlement. He had spent the past year gathering all the scientific evidence he could find, concluding that not only was fluoridation of a community water supply helpful to dental hygiene but also that such a process was neither harmful nor dangerous. This was government effort in support of a community, in Illinois, where the subject was being put to referendum, and community leaders had asked for USPHS help. This editorial is not about dentistry so I'll conclude the story, as most readers will have anticipated, with the knowledge that the public turned down my friend's carefully prepared logic.

The large amount of research and clinical data that has been accumulated concerning the interlocking of cigarette smoking and lung cancer would suggest that smoking would be a thing of the unhealthy past. Yet cigarette consumption continues to increase. Smokers can seldom explain why they smoke in spite of the logic which would oppose their doing so. Once in a freshman medical student lecture class, the hundred students and I managed to list twenty-seven reasons why people continue to smoke in spite of the implied connection with cancer. These ranged from simple desire for pleasure, being greater than fear, to the possible extreme of suicidal intent. Not one in our long list seemed very logical, yet each seemed to carry a bit of reality and may well have accounted for the illogical action of smoking. The same process could no doubt be used to partially "explain" (though not at all in the framework of logic my dentist friend had used) the mysterious workings of the community mind which rejected the benefits of fluorides and voted for their fears of it, and their fears of those who would poison them!

Now we as physicians are in much the same position as the persons in the two examples given. We

state our positions in regard to our view of the best method of providing health care for all of the people. We practice hard, and we meet intently with all sorts of persons, and many of them get better as a result of our ministrations. We organize hospital staffs and insurance companies, and we contribute our time and energy to medical education, to community activities, and to charity. Why then are we distrusted at best, ignored at worst, when it comes time for planning for medical service delivery? Some explain this on the semilogical stance that organized medicine was stubborn, obstinate, and ultra conservative at the time of the Medicare battle. Well, perhaps we were, but should a man, or a group, be punished forever for a view held long ago? There is just no connection between this perverted image of the greedy doctor, opposed to all progress and all serious efforts to help people, and either the average practitioner today or his organizations, the medical societies. There are no logical flaws, that I can find anyway, in the "Medical Care for Wisconsin" booklet prepared by the Medical Society of Milwaukee County. But then there were no real flaws in my dentist's logic for the use of fluorides, or in the logical experiments which show some integration between, if not actual causal link, cigarette smoking and lung cancer. And yet, we all seem to know that somehow it will come to naught, that our logic and real meaning will be lost in some other world sweep of activity which will determine our future. For awhile many of us (and I include myself in this) thought the problem was merely that doctors were too busy, or too virtuous, to mingle in "dirty" politics, and that precise attention to each issue, via each legislator, would turn the tide. This way we could defeat, for example, the chiropractic, that phoenix of health cults. Well, even the Governor's own Task Force, here in Wisconsin, presented full "logical" review, mostly negative to chiropractic, and you know how it continues to fare in this state.

It may be time to address ourselves to more complex aspects of human motivations, especially if we hope to understand, let alone influence, any part of the future of medicine. Logic seems all important, following our education, both before and during medical school. But can we afford to rest on this alone? It strikes me a little like arguing with a shark, that you are really a nice guy, kind to your wife and children, and a good physician.

Now I do not know where to go or where to look for more information on this aspect of human behavior, in political groups. True, I've spent my professional life in the shady corners of logic, in the psychoanalytic panorama of human actions and passions, few of which bear much of the light of logic. But my experience has been with individuals, not groups. And yet, in editorials to follow, I would like to discuss with you, my fellow targets of political activities, some ideas about nonlogical explanations of our position, our perceptions, and our potentials for action. I realize that the sequence "nonlogical explanation" is contradictory, but the human being forever seeks reason. Why not seek reason, beyond scientific logic, for what is happening to us. Watch this space. —RH

Must Medicine Always Be on the Defensive?

It seems that we as physicians have been forced into an unfortunate stance regarding our profession. Over the past two decades, but especially in the last five years, socially aware politicians and socially oriented persons of all sort have grasped somehow the *initiative* from us. They speak of the wonderful doctor and his skills and his dedication but immediately shift to their plan for bringing medical care to all. Their system is like this. Speak first of human rights, then of human needs, then of who ordinarily supplies those needs—and voila!—the speaker is *for the people,* and we the physicians, for not closing the gap, are *against the people.* Now of course they do not say we are against the people, only that we simply have not done the job—whether by stupidity, by cupidity or by malice is left to the imagination of the reader or the listener. And by some lack of perceiving the political drift of this sort of argument, we so often find ourselves defending medicine.

First of all medicine needs no particular defense—as medicine, so it can be unsightly of us to protest against those who are for motherhood, care, and the like. Secondly, the defensive position is singularly unsuited to any sort of figthing, as any boxer can tell you. Yet sometimes we let this happen without realizing it is so, and reduce our effectiveness by at least half. Thirdly, being on the defensive—that is looking at our adversaries in political areas from the questionable vantage point of being flat on our backs —carries the even greater danger that we attempt to manage by jumping to the other extreme. This results in exactly what the others wanted in the first place, that we overreact (out of sheer anxiety or panic) and give them twice what they asked for.

Now an excellent example of how to avoid all these traps is given by John Henningsen of Rice Lake in this issue of the Wisconsin Medical Journal. He does not attack big centers nor bow to them.

He does not overreact nor pound his chest. He simply writes in a most careful and lucid manner of what can be done with his size of medical unit in the particular area of coronary care. Information like this must start in medical journals. It's now to our editorial pages. Would it be reasonable to let the public know that physicians can function this way or should wait and let others do it for us?—RH □

LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

To Give Proper Credit

TO: THE MEDICAL EDITOR—In regard to the case report, "Localization of Bleeding Vascular Lesions of the Gastrointestinal Tract," published in the June 1973 issue of the *Wisconsin Medical Journal,* I feel it is appropriate to include the following addendum:

The technique described in the case report for localization of bleeding vascular lesions with a jejunostomy catheter, has been used in this and other patients by Dr. Sanford Mackman, Surgeon, Madison, Wisconsin, who developed the technique and has had experience with it. It is with deep regret that his name was omitted unintentionally from the case report, whereas credit should have been given for his contribution. Although it is a technique which apparently has been described before, the author did not have any knowledge of published information at the time of the writing of the report.

C. ARVANITAKIS, MD
Madison, Wisconsin

EDITOR'S NOTE: The *Wisconsin Medical Journal* received Doctor Arvanitakis' paper in January and accepted it in February. Doctor Mackman reported the same case in the March issue of the *American Journal of Surgery* under the title, "New Technic to Identify Vascular Lesions in the Gastrointestinal Tract."

Wants Case Reports on Insect Bites

TO: THE MEDICAL EDITOR—Again this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the type of reaction and the complications, if any, the age, sex, and race of the patient, the site of the bites, the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to the following address:

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Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS AUGUST 1973

THE AMERICAN ASSOCIATION of Medical Assistants, Inc., Wisconsin Society, held its 18th Annual Meeting on May 18, 19, and 20, 1973 in Milwaukee, Wisconsin.

Mrs. Roscelia Linton, Eau Claire, was installed as President at the evening banquet. Because the Society believed her acceptance speech was so eloquent and should be shared with all members and physicians, her permission was obtained to reprint it in the *Wisconsin Medical Journal* in its entirety.

President's Acceptance Speech

Honored guests, advisors, members, and friends:

There is a Chinese proverb that states: Every 1,000 mile journey begins with a single step! The Wisconsin Society was born, that first single step taken, and by this Annual Meeting you are aware, it is the 18th Annual Meeting. By our Wisconsin Law, we can declare ourselves NOW ADULTS . . . .

The first step was taken, firm foundations laid by the predecessor officers of this Society, as well as the Membership of this Society.

It is a revelation to read of its birth, those that made and laid the firm foundation for us to work with and upon. They forged ahead, bit by bit, to form component chapters and have 15 component chapters today in Wisconsin. We look with much pride over the roster of presidents who have carried this Society forward and onward, and we are also honored because most of them are here with us tonight. They brought us up, gave us rules, regulations, and fine objectives. Their leadership and examples are now a CHALLENGE FOR US IN THIS AGE OF ADULTHOOD!

Can we, in our now 18 years, keep moving ever onward, doing a job well? I feel we must show them that we can and that we will.

Increasingly, every day, we are expected to give more of our time and of our energies to our jobs, thereby, also more in the way of education and in training. This we must continue to do in ADULTHOOD.

A wise man, asked to give advice for people starting out in adulthood and on into life's journey, stated:

Belong to something bigger than yourself—
Work with others toward a common goal—
Do your part—
Take pride in doing a job well—
Work hard to make your ideas take shape in reality—
Help build something of lasting value.

You may have noticed that I am not using the word maturity; that has another added meaning to adulthood. It has the added meaning of mature in age, size, and strength—a state of maximum development. This we cannot declare!

Therefore, for your officers, your executive board, and you the members, now that we are adults, we must assume our adult responsibility. We are aware of the impact on us at this age, we have gained rights, privileges; but as adults now, we must have an awareness further to warrant the continuation of rights and privileges, a capability to take problems in stride. Our new status is a privilege but it does carry many responsibilities.

When you see or hear through your Chapter, letters and reports of the activities that are carried on by your State Society, listen, respond, and please participate. They are for you! This year in this beginning age of Adulthood, we are forging ahead into your every area with a Traveling Educational Symposium, bringing it closer to you, to become more acquainted with

the aims and goals of this Society, to broaden your scope and meet others of your immediate area and those in your field with mutual problems as well as the joys there are in the health-care field. Every area of the State will again have a Telephone/Radio series of conferences for you to advance in another form of educational program. These increase your knowledge in many areas, for you, the Medical Assistant, and does add to professionalism. Be alert to this, to add to your MATURITY.

During a hike in the woods, a troop of Boy Scouts came across an abandoned section of railroad track, each in turn tried walking the rails, but eventually lost his balance and tumbled off. Two boys, after considerable whispering, offered to bet that they could both walk the entire length of the track without falling off. Challenged to make good their boast, the two boys jumped on opposite rails, extended a hand to balance each other and walked the entire section of track with no difficulty. In a NUTSHELL, this is the principle of our being! We do things better, we produce more, we live better by helping each other. The person who lends a helping hand benefits himself at the same time as he helps the other person.

The reverse can also be true. When we do not help each other, when we do not cooperate, the whole of a Society's system can rattle and shake.

Let us have teamwork freely and voluntarily, always help each other. Should this of all societies be any different? I think not, and it has not been. Adulthood, and this responsibility, makes us accountable and responsible for a duty and a trust toward a state of maturity.

It is truly fitting that your 18th Annual Meeting Chairman and Committee have the theme, "Pathways to Progress." Those steps have been taken in that 1,000 mile journey and we will continue to step forward together and in the manner also of some of the lines from the great Fellowman Hymn that carry us on . . . .

Blest be the Tie that Binds,
Our hearts in Christian Love—
Our fears, our hopes, our aims are one,
Our comforts and our cares,

We share each other's woes,
Each other's burdens bear,
But, we shall be joined in heart,
And in perfect love and friendship reign.
And hope to meet again! □

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A Bacteriologic Study of Madison Area Beaches

STANLEY L. INHORN, MD
THERESA JORGENSON, MS
DONALD I. THOMPSON, MS

Madison, Wisconsin

For over 50 years, coliform bacteria counts have been used as a test to determine the suitability of beach waters for recreational use. Several methods have been proposed in an attempt to standardize collection techniques, laboratory procedures, and interpretation of results. Although standard methods for total bacterial counts and for coliform organisms have become generally accepted throughout the United States, these tests alone do not provide the basis for closing a swimming beach. When results are discrepant from one time to the next or from one collection site to another, a sanitary survey may be required to determine the magnitude of the problem. Even so, the basis for closing a swimming beach varies from one jurisdiction to another.

Fecal streptococci (enterococci) tests also have been used as a parameter of beach water quality, but the procedure has not been as widely applied in this country. In June 1967, the National Technical Advisory Committee on Water Quality Criteria recommended the use of the fecal coliform test to determine the quality of whole-body contact waters. This test, which is technically more difficult than the standard coliform count, offers several advantages from a public health standpoint. First, the test differentiates coliform organisms of human and mammalian origin from those contributed by other sources in nature. When fecal coliform organisms are present in significant numbers, this indicates that excreta of man or other warm-blooded animals have been introduced into the water system. Thus contaminated surface water, groundwater, or improperly treated sewage has found its way into the lake or river, indicating that the water is potentially dangerous to human health.

The fecal coliform test offers a second advantage in that it can be more reliably quantitated than the standard coliform test. The Advisory Committee recommended that water be declared safe if the geometric mean of not less than 5 samples within a 30-day period does not exceed 200 coliform bacteria per 100 ml, nor does more than 10 percent of total samples during any 30-day period exceed 400 bacteria per 100 ml. These standards have been adopted by the Wisconsin Division of Health.

Coliform bacteria are indicator organisms, which serve to warn that intestinal pathogens such as Salmonella or *Entamoeba histolytica* may be present. In the United States, however, intestinal disease outbreaks seldom have been traced to bathing beaches. On the other hand, infections of the skin, ears, eyes, and respiratory system have been frequently associated with swimming. Individual cases and even outbreaks of EENT infections have been traced to swimming in pools or natural waters. Therefore, in recent years the value of fecal indicators has been questioned. Accordingly, *Standard Methods for the Examination of Water and Wastewater,* 13th Edition,[1] included tentative methods (not standard methods) that may provide information of added public health significance. The two bacterial tests suggested by the Standard Methods Committee are *Staphylococcus aureus* and *Pseudomonas aeruginosa.*

In 1969, the chairman of the Commission on Health and Natural Resources of the State Medical Society of Wisconsin wrote to the membership concerning the possibility of disease transmission and propagation in the public swimming beaches and swimming pools of our state. The Commission expressed the concern of physicians about possible health hazards resulting from water pollution; members were asked to record documented infections, allergies, or irritations resulting from swimming and other water sports. Several questions also were directed to the Division of Health regarding standards for bathing areas. The proposals dealt with (1) eutrophication or over-enrichment of bodies of water, (2) physical qualities of water, such as temperature, turnover rate, swimming loads, (3) microbiological suitability, bacterial safety, and (4) algae.

Doctor Inhorn is Director of the State Laboratory of Hygiene, Miss Jorgenson is a microbiologist, and Mr. Thompson is Chief, Sanitary Bacteriology Unit.
Reprint requests to: State Laboratory of Hygiene, 465 Henry Mall, Madison, Wis. 53706.
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The major response of the Division of Health to these challenging questions was that from all standpoints, fecal coliform is the best indicator organism for evaluating suitability of recreational waters, based on state and national experience and numerous investigations. Nitrogen and phosphorus may make waters aesthetically unpleasant, since algae and aquatic weeds flourish, but the hazards are primarily from a safety and not a health viewpoint. Regarding physical factors, minimal and maximal (32.2 C) water temperatures and turnover rates (ratio of at least three) have been proposed for pools, but they have not been applied to natural bathing areas. The same may be said for swimming load.

The National Technical Advisory Committee on Water Quality Criteria noted in its report that while it would be desirable to test for microbial pathogens, time factors, complexity of tests, and economics mandate that the optimum solution is to monitor an indicator organism. Fecal streptococci are not as reliable as fecal coliforms since streptococci from other sources, such as plants and insects, yield positive test results. The Committee recommended using fecal streptococci only as a supplement to fecal coliform testing. Since no standard methods were available for *Staphylococcus aureus, Pseudomonas aeruginosa,* enteric pathogens or viruses in 1969, the Division of Health took no specific actions in response to these challenges from the State Medical Society.

This negative response in 1969 should not be interpreted as a lack of concern by governmental officials. As a matter of fact, Wisconsin has had a leadership role in its pollution abatement programs through the years. Since recreation is a major industry in Wisconsin, considerable effort has been expended to maintain the good quality of our water resources. Sanitary surveys conducted by district and local engineers and sanitarians coupled with frequent bacterial testing conducted by the State Laboratory of Hygiene have provided a reasonable assessment of water quality. The Committee on Water Pollution and more recently the Department of Natural Resources have conducted extensive surveys of the major watersheds in Wisconsin on a round-robin basis every summer. In addition, the State and Federal governments have provided funds to the University of Wisconsin Water Resources Center, to engage in research in eutrophication and waste treatment control. Other divisions and departments in the University have been funded for a variety of studies dealing with pollution abatement. At the State Laboratory of Hygiene, investigations have probed into problems such as swimmer's itch, algae growth, human enterovirus surveillance,[2] and salmonella in recreational lakes.[3]

The Salmonella study was conducted in Lake Mendota and its tributaries to determine whether pathogenic organisms can be recovered from recreational waters. The major focus for study was the University Creek—University Bay—Willow Beach area. University Creek receives a drainage outlet from University of Wisconsin Farms washwater and runoffs. Moore swabs and grab samples were taken from 11 stations in this area from July through December, 1968. Twenty-seven of 53 samples were positive for salmonella. Twelve serotypes of salmonella plus *Arizona hinshawii* were identified; several samples contained multiple serotypes. When salmonellae were recovered, fecal coliform counts were usually elevated, but several isolates were made when fecal coliforms were below the limit of detection. Despite the presence of these pathogens, no evidence of human disease could be correlated with swimming in Lake Mendota, according to the records of the Madison City Health Department. Epidemiologic studies elsewhere in the United States relating water sports and enteric infections have, for the most part, been negative. Futhermore, there has been a paucity of research on the infective dose necessary to cause salmonellosis from ingestion of contaminated water, so that from a public health standpoint it is difficult to assess the significance of isolating salmonella from recreational waters.

At the request of the State Medical Society, and with support from the society's CES Foundation, a similar study was carried out on Madison area beaches in the summer and fall of 1972. The major purpose of this investigation was to determine the value of the *Staphylococcus aureus* and *Pseudomonas aeruginosa* monitoring procedures, tentative methods listed in *Standard Methods*.[1] Samples were collected by the Madison Health Department personnel as part of its regular weekly surveillance. Eleven samplings between July 17 and September 25 were tested in the Madison Health Department Laboratory for fecal coliforms and fecal streptococci. Samples were then turned over to the Sanitary Bacteriology Unit of the State Laboratory of Hygiene for further examination. All samples were refrigerated in transit, and tests were initiated within 6 hours of collection. The methods used were those described in the 13th Edition of *Standard Methods for the Examination of Water and Wastewater*. These included the membrane filter technique for staphylococci (followed by confirmatory testing) and the multiple tube technique for *Pseudomonas aeruginosa*.

The results of this study are shown in Table 1. No coagulase-positive staphylococci were found on any of the membrane filter cultures. The *Pseudomonas aeruginosa* most probable numbers (MPN) were very low, ranging from 0 to 4.8 per 100 ml. There appears to be no correlation between fecal streptococci or fecal coliforms and *Pseudomonas aeruginosa*. Fecal coliforms and fecal strep show a rough correspondence, with the fecal streptococcus total mean being 240, compared with a geometric mean of 94 for fecal coliforms.

The lack of recovery of *Staphylococcus aureus* may be explained in several ways. If these organisms originate only from the skin and mucous membranes of humans, it is conceivable that the large volume of water in lakes dilutes out the *Staphylococcus aureus* being shed from swimmers.

TABLE 1—*Average organism counts, eleven sampling times, Madison recreational waters*

Sample site	*Fecal streptococcus* Geometric mean #/100 ml	*Fecal coliform* Geometric mean #/100 ml	*Pseudomonas aeruginosa* Average MPN/100 ml	*Staphylococcus aureus* #/100 ml
Clarke	110	22	.40	0
Lakeland	400	130	3.18	0
University Creek	4100	2100	1.81	0
Maple Bluff	900	270	1.70	0
Warner	470	140	1.47	0
Mendota	300	75	1.30	0
Tenney	130	33	0	0
James Madison	560	57	1.32	0
University Y	47	35	.92	0
Willows	140	70	1.70	0
Olbrich	250	170	.83	0
Vilas	120	92	.46	0
Marshall	140	71	.46	0
Esther	160	70	.40	0
Olin	770	66	0	0
South Shore	97	49	3.35	0
Brittingham	97	34	3.03	0
Starkweather Creek	2700	1200	2.98	0
Mouth Yahara River	810	520	4.80	0
Locks Yahara River	35	30	1.40	0
Shorewood	110	41	1.05	0
Spring Harbor	150	70	.86	0
Total Mean Value	240	94	1.52	0

The survival time of these organisms in recreational waters may be short. Finally, the laboratory system may not be selective enough, since large numbers of other organisms grew on the membrane filters incubated in M-Staphylococcus Broth. A more selective medium may help eliminate this problem. The fact that many competing organisms were present also may have caused poor recovery of *Pseudomonas aeruginosa*. Better inhibitory media may enable more accurate enumeration of both of these bacteria. Thus the new tentative methods for evaluating swimming beach quality did not appear to be of much value as applied in this study.

TABLE 2—*Recovery of fungi from Madison recreational waters*

Sample site	Fungus species
Clarke	Saprophytic fungi unable to speciate
Lakeland	*Penicillium* sp.; *Mucor* sp.
University Creek	*Mucor* sp.; *Rhizopus* sp.
Maple Bluff	*Mucor* sp.; *Penicillium* sp.
Warner	*Rhodotorula* sp.; *Fusarium* sp.; *Mucor* sp.
Mendota	*Rhodotorula* sp.; *Mucor* sp.; *Penicillium* sp.; *Fusarium* sp.
Tenney	*Oospora* sp.
James Madison	*Fusarium* sp.
University Y	Negative
Willows	*Penicillium* sp.
Olbrich	*Penicillium* sp.; *Fusarium* sp.; *Aspergillus* sp.; *Mucor* sp.
Vilas	*Penicillium* sp.
Marshall	Negative
Esther	*Cladosporium* sp.; *Penicillium* sp.
Olin	Saprophytic fungi unable to speciate
South Shore	Negative
Brittingham	*Fusarium* sp.; *Penicillium* sp.
Starkweather Creek	Negative
Mouth Yahara River	Negative
Locks Yahara River	Negative
Shorewood	*Fusarium* sp.; *Penicillium* sp.
Spring Harbor	Negative

Additional pathogens were investigated in selected samples. Swabs collected from 5 regular sites were examined for viruses (method of Nelson, et al[2]) and salmonella (method of Claudon, et al[3]). No viruses were recovered. From the Lakeland Beach, one sample yielded two *Salmonella enteriditis* serotypes, *newport* and *typhimurium*. In a final study, samples taken from 22 locations were examined for fungi, which have been associated with external otitis and allergic respiratory disease (Table 2). Saprophytic fungi were recovered from 16 samples, in 9 cases multiple species were identified. The results are not surprising since these organisms and their spores are widespread in nature.

Previous studies to measure the reliability of indicator organisms for determining recreational water quality have shown that swimmers have uniformly higher illness rates than nonswimmers, with EENT ailments dominating (50%), but also with gastrointestinal disturbances (20%), and skin irritations (30%).[4] When the coliform density was elevated, the frequency of illness was generally higher. There are several specific diseases associated with recreational waters in the U.S., including swimmer's itch (schistosome dermatitis), leptospirosis, toxic blue-green algae, and others.[5] Additional hazards include physical-chemical eye irritations, toxic chemicals, and weed irritations. Therefore, bacterial indicator standards cannot guarantee safety from all health hazards related to recreational waters.

As noted in *Standard Methods,* routine sampling of water alone cannot give definite information regarding its quality. Laboratory results must be interpreted in conjunction with sanitary survey data. For swimming pools, it has been proposed that staphylococcus counts may be the best bacterial indicator for detecting unsafe conditions.[6] From studies conducted at the State Laboratory of Hygiene, however, it has been shown that pool conditions change rapidly, so that frequent pool-side tests for disinfectant and pH are necessary. The present study suggests that neither the staphylococcus nor pseudomonas methods are sensitive enough for natural waters. Perhaps improved microbiological methods in the future will permit direct quantitative evaluation of these and other human pathogens in beach waters.

ACKNOWLEDGMENT: The authors wish to acknowledge the cooperation of Mr. Thayer Burnham, Laboratory Director, Madison City Health Department; and Mr. Donald Nelson, Mrs. Eleanor Christenson, and Mr. James Stoebig, State Laboratory of Hygiene.

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Mower Danger Stressed by MDs

The roar of the power lawn mower is heard in the land again. And, despite safety features and warnings, its victims are being seen in the emergency rooms.

William P. Graham III, MD, chief, Division of Plastic Surgery, and William E. DeMuth, MD, Dept. of Surgery, Milton S. Hershey Medical Center, Pennsylvania State U. College of Medicine, have studied the dynamics of injuries from power mowers.

Dr. Graham told the Section on General Surgery Sunday that a piece of wire or other small object hurled from the discharge chute by a rotary blade has the same momentum as a 2½-pound axe head that has fallen 370 feet.

"**THESE** calculations, which by any standard must be considered conservative, indicate that the rotary power lawn mower is a very potent wounding agent," he said.

In their own experience, Drs. Graham and DeMuth indicated, they have found the hands to be particularly vulnerable, particularly the second and third ("index" and "long") digits.

Among the ways that rotary power mowers may inflict injury, Dr. Graham said, are:

- Disintegration of the rotary blade.
- Transmission of force to the object (stone, wire, etc.) that is struck.
- Direct contact with the moving blade.
- Being hit by the machine itself.
- Burns or blast injuries from ignition of fuel or explosion of the power unit.—*AMA Daily Bulletin* of AMA Annual Meeting, June 25, 1973.

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Coronary Care Unit in a Small Hospital

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THE BENEFITS PROVIDED by an intensive coronary care unit have been well documented for the treatment of myocardial infarctions.[1,2] Most reports of their efficacy have come from large medical centers where cardiologists have reported consistently improved mortality rates from the pre-coronary care unit era. Whereas many smaller hospitals have established coronary care units, statistical analyses of these units and their efficacy have not been widely reported. It is the purpose of this paper to report such an experience over a four-year period in a 58-bed rural hospital which is relatively isolated from large medical centers and is staffed solely by family physicians.

Equipment, Procedures and Staffing

The three-bed unit is equipped with individual bed monitors with a central monitor located at a nursing station with an alarm write out. A crash cart with a defibrillator, monitor and electrocardiographic (EKG) paper write out, serves the unit itself and can be used in the x-ray department while temporary transvenous pacemakers are being inserted. These pacemakers are inserted using a fluoroscopic image intensifier usually via an external jugular vein.

Weekly training courses given by the staff to nursing personnel are followed by regular in-service training programs of lesser frequency. A teaching manual was written and is used as a basic outline for each group of nurses taking the course. Most hospital personnel, including technicians, ambulance drivers, aides, and the like, receive some form of in-service education to help them understand how they, in their respective ways, can facilitate the intensive

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coronary care unit (ICCU) procedures. After the registered nurses (RNs) take an appropriate training course, their proficiency is determined by a written and practical examination. If this is passed, the RN is considered qualified to perform ICCU procedures such as defibrillation. Because of the relatively small size of the unit, the RN always has responsibility on a general medical floor in addition to her work in the ICCU. This does not create any particular problem. ICCU orders, including laboratory, x-ray and emergency procedures, are standardized and used by all the staff to generally increase the efficiency of all aspects of care. These are re-evaluated and revised as needed. Telephone consultations with cardiologists for the purpose of reading cardiograms or discussing therapy are used freely. Use of the unit for other than cardiac-related cases is discouraged and the staff cooperates very well in this respect.

Data

Determination of the diagnosis of a myocardial infarction is based on a point system with five points being necessary to establish the definite diagnosis of an infarct.

EKG	*Positive*	*Borderline*	*Negative*
Transmural	5	1	0
Non-Transmural	2	1	0
Clinical Picture	2	½	0
Serum Enzymes	1	½	0
Autopsy	5	—	0

The data were obtained from a four-year period but divided into two-year intervals to determine if any trends had occurred. Tables 1-7 show the statistical analysis of our experience.

Comment

Most of the data are self-explanatory and require no further elucidation. There are some areas of special interest, however.

In the second two-year period it is obvious that the staff was considerably more liberal in its use of the unit for diagnostic purposes. The number of admissions almost doubled. The majority of the increased number of admissions was found to have some coronary artery disease, and for this reason the increase is probably justified. In the same regard there was an increased tendency for doctors to keep patients with myocardial infarctions in the unit almost one day longer. This appeared to be related more to the security the unit offered the doctor than to an actual need for the patient since the mortality rate was essentially unchanged in the two periods.

Coronary care units in general have reduced mortality rates of myocardial infarctions from 30-35% to 15-20%.[3] The overall mortality rate of 16.4% in this study is comparable. Most strikingly, however, is the low mortality rates in the younger patients, with 5.4% and 7.3% mortality rates found in the under age 60 and under age 70 age groups respec-

TABLE 1 — *Admissions*

		July 1968 to July 1970	*July 1970 to July 1972*	*Four Year Totals*
7:00 am to 4:00 pm shift		73	107	180
4:00 pm to 11:00 pm shift		26	107	133
11:00 pm to 7:00 am shift		23	24	47
Total Admissions		122	238	360
Infarction Present:	Number	68	72	140
	Percent	56%	30%	39%

TABLE 2 — *Length of stay of patients with myocardial infarctions*

		July 1968 to July 1970	*July 1970 to July 1972*	*Four Year Totals*
In ICCU:				
Patient Died:	Hours	93	56	75
	Days	3.9	2.4	3.1
Patient Lived:	Hours	118	137	130
	Days	4.9	5.7	5.4
In Hospital:				
Patient Lived:	Days	19	19	19

TABLE 3 — *Myocardial infarction mortality rate*

	July 1968 to July 1970		*July 1970 to July 1972*		*4 Year Total*	
	Lived	Died	Lived	Died	Lived	Died
Anterior	28	6	29	6	57	12
Posterior	26	3	31	6	57	9
Anterior and Posterior	3	2	0	0	3	2
Total	57	11	60	12	117	23
Percent Deaths	16.2%		16.6%		16.4%	

Myocardial infarctions below age 60		Myocardial infarctions below age 70	
Total	37	Total	76
Died	2	Died	6
Percent died	5.4%	Percent died	7.3%

TABLE 4 — *Myocardial infarction deaths*

Dates	*July 1968 to July 1970*			*July 1970 to July 1972*			*4 Year Total*		
Age at death	No.	M	F	No.	M	F	No.	M	F
Below 40	0	0	0	0	0	0	0	0	0
40-44	1	1	0	0	0	0	1	1	0
45-49	0	0	0	0	0	0	0	0	0
50-54	0	0	0	0	0	0	0	0	1
55-59	1	0	1	0	0	0	1	0	1
60-64	2	1	1	1	1	0	3	2	1
65-69	0	0	0	1	1	0	1	1	0
70-74	3	2	1	4	3	1	7	5	2
75-80	1	0	1	4	2	2	5	2	3
80-84	3	1	2	1	1	0	4	2	2
Over 85	0	0	0	1	0	1	1	0	1
TOTAL	11	5	6	12	8	4	23*	13	10

* Three patients discharged from ICCU alive, but died in the hospital.

tively. These younger groups presumably had basically more adequate myocardial reserve, and by prevention of a fatal arrhythmia they were able to withstand the cardiac insult better than the older group where power failure was much more common. With the emphasis on prevention of arrhythmias in the unit, the number of myocardial infarctions without any significant arrhythmia increased from 21% to 36% over the years studied. Earlier detection and treatment of minor arrhythmias undoubtedly was a factor. Cases of ventricular fibrillation were quickly terminated with either drugs or cardioversion, but some progressed to death by another mechanism. The patients who had ventricular fibrillation and eventually died were felt to be power-failure deaths. Third degree heart blocks were treated with temporary transvenous ventricular pacemakers after a fair trial of drug therapy. About half of the patients did not respond to the medications and needed a pacer.

Intensive cardiac care has improved the treatment of myocardial infarctions in our hospital as it has in others. Death from arrhythmias has been largely eliminated. Death from power failure remains a significant problem, but technological advances at the present time do not seem to be such that we can anticipate a great change in this area. Therefore, we must look to more promising avenues of approach in the treatment of myocardial infarctions. Studies show that up to 70% of all patients with myocardial infarctions who die, do so before they reach the hospital.[4-6] Certainly this prehospital care would seem to be the area where the greatest effort against coronary artery disease should be exerted in the future.

TABLE 5 — *Myocardial infarctions lived*

Dates	*July 1968 to July 1970*			*July 1970 to July 1972*			*4 Year Total*		
Age at death	No.	M	F	No.	M	F	No.	M	F
Below 40	1	1	0	0	0	0	1	1	0
40-44	4	4	0	2	2	0	6	6	0
45-49	4	4	0	5	4	1	9	8	1
50-54	6	5	1	2	2	0	8	7	1
55-59	5	3	2	6	5	1	11	8	3
60-64	6	5	1	13	11	2	19	16	3
65-69	10	8	2	12	10	2	22	18	4
70-74	8	3	5	11	9	2	19	12	7
75-79	6	1	5	7	4	3	13	5	8
80-84	6	1	5	2	1	1	8	2	6
Over 85	1	0	1	0	0	0	1	0	1
TOTAL	57	35	22	60	48	12	117	83	34

TABLE 6 — *Primary diagnosis if myocardial infarction not present*

	July 1968 to July 1970	*July 1970 to July 1972*	*Four Year Totals*
Coronary Artery Disease Syndromes	32	110	142
UGI Disease Syndromes	6	20	26
Pneumonia	3	8	11
Digitalis Intoxication (Probable)	3	5	8
Paroxysmal Atrial Tachycardia	0	5	5
Electrolyte Imbalance	3	1	4
Miscellaneous	7	17	24
Total	54	166	220

TABLE 7 — *Major arrhythmias in myocardial infarctions*

	July 1968 to July 1970	*July 1970 to July 1972*	*Four Year Totals*
None			
Number	14 of 68	26 of 72	40 of 140
Percent	21%	36%	29%
Ventricular Fibrillation			
Number	5	6	11
Died	2	3	5
Third Degree Heart Block			
Number			12
Died			3

Insertion of Pacemaker for Third Degree Heart Block	Number	Died
Not attempted	5	1
Attempted, unsuccessful	2	1
Attempted, successful	5	1

Summary

A four-year statistical study of a small hospital coronary care unit is presented. The results would indicate that treatment of myocardial infarctions in a small hospital by family physicians compares favorably with that in larger institutions. Fatal arrhythmias as a cause of death in basically good hearts have largely been prevented but power-failure deaths still seem unpreventable in most cases. Prehospital treatment of coronary artery disease would appear to be the most rewarding area of endeavor in lowering the mortality rate from myocardial infarctions.

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Bone Marrow Scanning in Hematological Disorders

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EXAMINATION OF THE BONE marrow by aspiration or biopsy is an important facet in the evaluation of hematological disorders. However, the marrow specimen represents only a small portion of the total bone marrow, and the sampling is limited to certain easily accessible sites. This specimen will be truly representative if the disease process affects the marrow equally throughout its distribution. In a number of hematological disorders, however, especially the myeloproliferative diseases, marrow distribution is affected nonuniformly throughout the skeleton. In addition, the various cellular components—erythroid, myeloid, megakaryocytic, and reticuloendothelial—may be affected unequally and may respond differently to various stimuli or the removal of these stimuli.

The marrow reticuloendothelial (RE) elements may be labeled by phagocytosis of radiocolloids such as Tc-99m sulfur colloid, and its distribution monitored by a scintillation camera or rectilinear scanner. The erythropoietic elements can be labeled by the administration of radioiron (Fe-59); however, the relatively large radiation exposure by this isotope limits its clinical use in that only minute doses can be administered which require special instrumentation for localizing its body distribution. A short lived isotope of iron, Fe-52, may be administered in doses large enough to be visualized with a scintillation camera;[1] however, its general availability is limited since a cyclotron is necessary for its production. Although the RE and the erythroid elements may not be affected equally by some disease processes, the ready availability of the Tc-99m sulfur

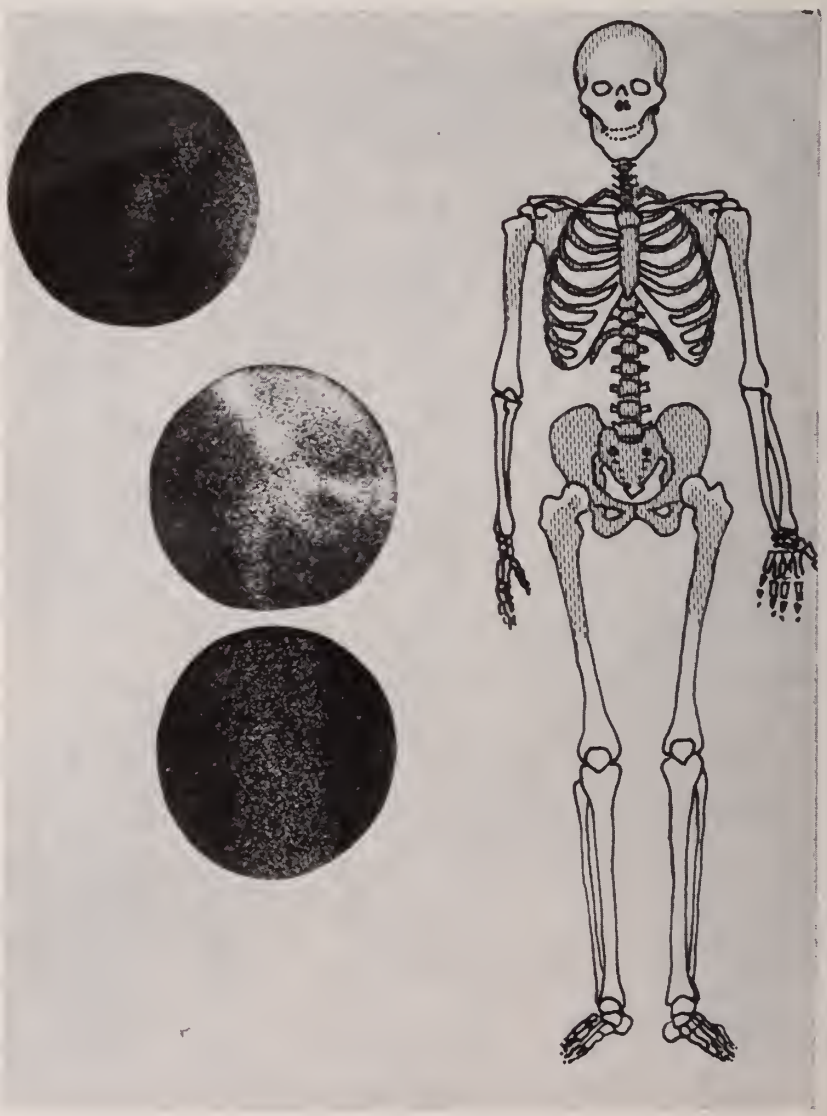

Figure 1—Normal RE marrow scan (left) and anatomical distribution of active bone marrow in the normal adult (after Hashimoto[5]).

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colloid and a scintillation camera or recti-linear scanner in most hospitals makes bone marrow scanning of the RE distribution a useful procedure in the diagnosis and management of patients with hematological disorders.

Materials and Method

The RE elements of the marrow were labeled with Tc-99m sulfur colloid prepared either from a commercial source (Tesuloid®, Squibb)[2] containing a gelatin carrier or carrier-free colloid prepared by the method of Hellman, et al.[3] Control of particle size was achieved by discarding cloudy or turbid preparations and excluding samples with microscopically visible particles. The diameter of the colloid particles was thus limited to 0.1 microns or less. No significant amount of free Tc-99m was detected by paper electrophoresis of the colloid sample.

Blood clearance and organ uptake studies have shown that most of the radiocolloid localizes in the liver, spleen, and marrow within five minutes and has reached a stable level in these organs at 15 minutes. Eighty percent to 90% is taken up by the liver and spleen and the remaining 10% to 20% is distributed throughout the active marrow. Fifteen minutes after the intravenous injection of 2-4 mCi of Tc-99m sulfur colloid, photoscintigrams representative of the marrow distribution were taken with a scintillation camera, including the shoulder, pelvis, femur, and tibia.

The radiation dose in a 70 Kg man for a 4 mCi dose of Tc-99m sulfur colloid are 70 mrem to the bone marrow, 900 mrem to the spleen, 500 mrem to the liver, and 35 mrem to the whole body.[4]

(a) (b) (c)

Figure 2—RE marrow scans in patients with (a) hereditary spherocytosis, (b) hypoplastic anemia, and (c) red cell aplasia.

(a) (b) (c)

Figure 3—Pelvis and lower extremity RE marrow scans in a patient with hereditary spherocytosis: (a) pre-splenectomy, (b) one month post-splenectomy, and (c) three months post-splenectomy.

(a) (b) (c)

Figure 4—RE marrow scans of three patients with polycythemia vera showing various degrees of peripheral extension of uptake (a, b, and c).

(a) (b) (c)

Figure 5—Right lower extremity RE marrow scans in patients with myelofibrosis showing varying degrees of uptake. In b and c dense uptake in the abdomen is due to massive hepatic enlargement (incompletely shielded).

Results

1. Normal Subjects

In normal adult subjects the Tc-99m sulfur colloid is taken up primarily by the central skeleton, including the spine, pelvis, ribs, sternum, shoulder girdle, and the proximal half of the femur and humerus (Fig. 1).

2. Hemolytic Anemia

All seven subjects with chronic hemolytic disorders including five patients with hereditary spherocytosis prior to splenectomy showed heavy colloid uptake in the distal femur and proximal tibia (Fig. 2a). Serial scans were performed in four patients with hereditary spherocytosis. In all increased activity persisted for three months following splenectomy and receded slowly thereafter (Fig. 3).

3. Marrow Hypoplasia and Red Cell Aplasia

Patients with chronic anemia due to a hypoplastic marrow showed marked decrease in bone marrow uptake of Tc-99m sulfur colloid (Fig. 2b). A different pattern was observed when the erythroid compartment alone was affected as in red cell aplasia. Two patients with red cell aplasia with Coombs positive anemia and marrow erythroblastopenia were studied before and after therapy with testosterone in one patient and treatment of the Hodgkin's disease with vinblastine in the other. In both a good response to therapy was reflected by return to normal of the hematocrit and marrow histology, and loss of the positive Coombs reaction. The Tc-99m sulfur colloid scans performed prior to initiation of therapy gave the impression of peripheral expansion of uptake (Fig. 2c), while repeat scans six months later showed a normal uptake limited to the central marrow.

4. Myeloproliferative Disorders

Six patients with polycythemia vera treated with phlebotomy alone have shown patterns of RE marrow distribution ranging from normal to moderate or marked peripheral extension with continued good central marrow (pelvic) uptake (Figs. 4a, b, and c).

One patient with primary thrombocythemia with a platelet count of 2 million but no increase in hematocrit or white blood cell count and without evidence for marrow fibrosis showed no peripheral extension of the RE elements.

A total of twelve patients with myelofibrosis and myeloid metaplasia (3 men and 9 postmenopausal women) were studied. Pelvic uptake of Tc-99m sulfur colloid was markedly decreased and uptake in the distal extremities ranged from increased to no remaining uptake in the entire skeleton (Figs. 5a, b, and c). Progressive loss of uptake in the lower extremities did correlate with a more advanced and refractory state of myelofibrosis.

Discussion

In normal subjects the distribution of RE and erythroid elements are identical. This has been shown by anatomical[5] and isotope studies.[6,7] In disorders which affect the distribution and composition of these two compartments equally, the labeling of phagocytotic cells with Tc-99m sulfur colloid is the method of choice for visualizing marrow distribution since it is inexpensive, readily available, and exposes the patient to only low amounts of radiation.

Factors which result in stress on the erythropoietic marrow compartment, such as hemolytic disease, will stimulate the expansion of erythroid marrow into the long bones, transforming the previously reserve (yellow) marrow into active (red) marrow. Since this activity initially involves only the erythroid element in the acute hemolytic state, no expansion of uptake in Tc-99m sulfur colloid is observed. However, in chronic hemolytic disease there is marked extension of the RE elements as demonstrated in the hereditary spherocytosis patients. Furthermore, after the hemolytic process has been ameliorated, for example by splenectomy in hereditary spherocytosis, the RE distribution remains expanded for at least three months. Thus, there appears to be a stimulus which is directed at the marrow RE cells, although it is the erythropoietic cells which are primarily affected by a hemolytic process.

In the hypoplastic anemias, RE uptake is variable, possibly reflecting whether the marrow stroma has been affected. In two patients with marrow erythroblastopenia on an autoimmune basis, the RE uptake was actually extended possibly due to a stimulus similar to that occurring in chronic hemolytic disorders.

In patients with polycythemia vera the RE uptake reflected a normal or moderately extended distribution. In most cases the central marrow was not affected and showed a normal uptake. These, however, were patients who were relatively early in the course of the disease and were controlled with phlebotomies alone. In 12 patients with myelofibrosis there was a shift of RE marrow uptake from the central adult marrow area (dorsal and lumbar spine and pelvis) into the peripheral juvenile areas (distal femur and tibia). Marked uptake was also noted in the massively enlarged livers and spleens of these patients.

The patterns observed in our patients with myelofibrosis were similar to those observed by Van Dyke and coworkers[8] in the late stages of polycythemia vera in the presence of myeloid metaplasia. These workers suggest that there is a slow progression of polycythemia vera leading to a "burned out" stage with myelofibrosis and myeloid metaplasia. This is thought to come about by progressive loss of central marrow with concomitant extension peripherally, until terminally hematopoiesis occurs only in the liver and spleen.

In our patients follow-up scans over a period of six months to one year did not show significant changes; however, for the most part this condition progresses slowly and may remain stable for considerable periods. However, the degree to which central and peripheral marrow uptake was reduced in our patients did correlate to the clinical severity of the disease and refractoriness to therapy with corticosteroids and androgens. Since those patients who did not respond to treatment had no detectable uptake of Tc-99m sulfur colloid except in the liver and spleen, it might be postulated that persistence of a vital marrow bed or stroma, of which RE phagocytic activity may be an indicator, is necessary for stimulation of marrow activity to take place.

Bone marrow scanning with Tc-99m sulfur colloid has proved itself as a rapid and safe procedure which may be performed simultaneously with a Tc-99m sulfur colloid liver and spleen scan utilizing equipment already available for routine liver and spleen scanning. Scanning of the bone marrow has been helpful in determining the duration of hemolytic disorders, may be used to follow effectiveness of therapy, and may become useful in predicting response to therapy in the hypoplastic anemias and the myeloproliferative disorders. Work is presently in progress to explore the long-term effects of radiation and chemotherapy on the regenerative ability of the bone marrow, including periodic scanning of the RE marrow in patients with lymphomas and other malignancies.

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Combined Congenital Defects of the Anterior Abdominal Wall, Sternum, Diaphragm, Pericardium, and Heart: A Case Report and Review of the Syndrome

WILLIAM M TOYAMA, MD, Marshfield Clinic, Marshfield, Wis. *Pediatrics* 50:778–792 (Nov) 1972

Doctor Toyama presented a case of thoraco-abdominal ectopia cordis with a rare pentad of congenital defects involving the sternum, diaphragm, pericardium, heart, and anterior abdominal wall. The patient was born with all five defects plus herniation of small bowel into the chest. Resuscitation was followed by surgical reduction of the hernia, closure of a diaphragmatic-pericardial defect, and conservative treatment of the omphalocele.

In the seventh week, iatrogenic rupture of the eschar covering the omphalocele required skin closure over the evisceration. Acute cardiac failure after skin closure was dramatically relieved by use of an inclined infant seat in the incubator. The child developed well initially, but progressive dyspnea and cyanosis prompted cardiac catheterization and angiography when she was 19 months old. A Blalock shunt was constructed, but the child died four days later at which time autopsy revealed a multitude of intracardiac and extracardiac defects.

Sixty cases from the literature and the case reported here are classified into 36 cases of the full syndrome, 17 suspected cases, and 8 confirmed cases of incomplete expression. The syndrome, its variations, and their relationship to other forms of ectopia cordis are delineated in the review. □

Expectorant Effect of Glyceryl Guaiacolate in Patients with Chronic Bronchitis

S R HIRSCH, MD, FCCP, P F VIERNES, MD and R C KORY, MD, FCCP, Wood VA Hosp, Milwaukee, Wis: *Chest* 63:9–14 (Jan) 1973

Glyceryl guaiacolate (GG) is one of the most common expectorants given to patients with chronic bronchitis. In an in vitro study, GG was found to be no more effective than water in lowering the consistency (viscosity) of 27 sputum specimens obtained from various patients with chronic bronchitis.

In a clinical study of 11 patients with chronic bronchitis, GG at dosage levels of 800 mg and 1,600 mg daily was no more effective than the placebo in lowering sputum consistency, increasing sputum volume, or improving ventilatory function.

Finally, in a double-blind evaluation of ten patients over a 20-day period, the ease of expectoration with GG was no different than with a placebo. On the basis of these studies, GG appears to be ineffective as an expectorant in patients with chronic bronchitis. □

Basophil Degranulation: A New Method of Observation and Its Correlation with Skin Testing

S R HIRSCH, MD and J E ZASTROW, Wood VA Center, Milwaukee, Wis: *J Allergy Clin Immunol* 50: 338–347 (Dec) 1972

For improved study of the atopic reaction, we have devised a new method of assessing degranulation of the human basophil. The procedure involves the concentration of basophils from 20 ml of peripheral blood, incubation of the basophil concentrate with dilutions of antigen extract, counting of non-degranulated basophils, and comparison of the maximal percent degranulation of the test suspensions with a control. A significant difference in degranulation between the control and test suspensions constitutes a positive test.

In a group of 17 ragweed-sensitive patients, the mean maximal percent degranulation was 77.4 percent. In a group of 13 nonsensitive subjects, the mean maximal percent degranulation was 8.8 percent ($p < 0.01$). The procedure is reproducible, specific, and correlates with the results of skin testing. □

Treatment and Prevention of Childhood Lead Poisoning: New Approach

SANFORD J. BROWN, MD
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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

LEAD POISONING is perhaps the most serious toxicologic problem in children today. Although it causes 5 percent of total childhood poisonings, it accounts for far more of the mortality from such poisoning. Attendant morbidity takes the form of behavioral aberrations, seizure disorders, mental retardation, and nephropathy. Even subclinical exposures to lead inhibit certain enzyme systems. Although lead poisoning is an illness of known cause, in most cases readily diagnosed, treated and prevented, it continues to be a problem of epidemic proportions in many of our major cities.

Epidemiology

Screening studies in New York, Chicago, Baltimore, and Philadelphia indicate that 5 to 10 percent of children in these inner cities have absorbed potentially dangerous quantities of lead, and that 1 to 2 percent have symptoms compatible with acute intoxication.[1] The triad of childhood lead poisoning comprises the child, the parent, and the environment. The latter is typically a slum with deteriorating houses painted generations ago with a lead-based paint. Fifty to 70 percent of these houses contain dangerous quantities of lead on window sills, walls, and exteriors. A lead paint chip may contain in excess of 100 mg of lead whereas the safe daily intake is 0.5 mg. Mothers of lead-poisoned children tend to be unobservant and crisis-oriented, only bringing the child into the clinic when he is moribund. These mothers also may have the habit of eating nonfoods, like starch and clay. This predisposition toward an habitual, purposeful, compulsive

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search for nonfoods is termed "pica" and is estimated to affect up to 50 percent of children from middle and lower socio-economic groups. Pica has not been shown to be related to nutritional deficiency or anemia. It does not usually occur in children under one year of age and is rarely seen after age 5. There appears to be a selective process operant in what a child will eat. Children who eat dirt may not eat plaster. Although plaster is said to have a sweet taste, the reason a child chooses lead paint chips to ingest is unknown.

Symptoms

Symptoms of lead intoxication usually develop insidiously after four to six weeks of continued ingestion. Initially there is a progressive anorexia, hyperirritability, clumsiness, and an unwillingness to play. Other nonspecific signs include fatigue, headache, abdominal pain, and vomiting. With continued ingestion, lassitude progresses to drowsiness and stupor, and the vomiting may become persistent and forceful after eating. Convulsions can occur and fulminating encephalopathy is most often seen in the 15- to 30-month-old infants while older children exhibit sporadic convulsions, behavioral problems, and mental retardation. Symptoms are most severe in the summer months, presumably because the ultra-violet component of sunlight increases the absorption of lead from the intestine. Symptoms of chronic lead poisoning depend upon the rate of absorption from the gut and from lead deposits in the bone, with transfer to the blood or soft tissues.

Diagnosis

It has been said that the number of lead poisoning cases you find depends upon how hard you look. Certainly a positive history for pica along with concomitant vomiting, convulsions, and coma, with increased cerebral spinal fluid protein and elevated spinal fluid pressure, should make the physician consider plumbism. The definitive diagnosis, however, requires a demonstration of excessive body lead burden as shown by an elevated blood lead level.

Normal exposure of both adults and children is associated with blood lead concentrations of 15-40 μg per 100 ml of blood. Blood levels of 40-49 μg per 100 ml should have another determination of blood lead, and inquiry should be made concerning the pica habit. Children with blood lead levels ranging from 50-79 μg per 100 ml should be referred immediately for evaluation and should be considered suggestive cases of lead poisoning. In the absence of clinical symptoms, the United States Public Health Service recommends the following tests for children within the 50-79 μg per 100 ml range to confirm the diagnosis:[2]

1. Urinary excretion in 24 hours of more than 1.0 μg of lead per milligram of Ca-EDTA administered intramuscularly at a dose of 50 mg per kg of body weight—the total dose not to exceed 1 gm of Ca-EDTA;
2. Serum delta-aminolevulinic acid (ALA) level of greater than 20 μg per 100 ml of whole blood using the Haeger-Aronson method;
3. Urinary output of coproporphyrin greater than 150 μg per 24 hours;
4. Urinary output of delta-aminolevulinic acid greater than 5 mg per 24 hours;
5. The presence of basophilic stippling of red blood cells, "lead lines" in long bone x-rays, or a strongly positive urine spot test for coproporphyrin may be considered indicative.

Children with blood lead concentrations in excess of 80 μg per 100 ml regardless of the presence or absence of clinical symptoms or other laboratory findings, should be considered unequivocal cases of lead poisoning, hospitalized and treated immediately as a medical emergency. This recommendation is made because the risk of acute encephalopathy is the greatest in this group. At least 25 percent of children with encephalopathy will sustain permanent brain damage, whereas treatment prior to the onset of encephalopathy may improve the prognosis.[3] If encephalopathy is suspected, a lumbar puncture should be avoided, for there is a grave risk of herniating the cerebellum.

Other symptoms are a hypochromic, microcytic anemia, a hemoglobin under 10 gm per 100 ml, a reticulocytosis, glycosuria, and in acute intoxication, radiopaque material in the gut on an abdominal x-ray film. Since almost all the lead is within the red cell and little in the plasma, the red cell mass is an important factor in assessing toxicity. An anemic child could have a lower lead level than a non-anemic child and yet be in much worse shape.[4]

Treatment

The first step in the treatment of lead poisoning is to separate the child from sources of lead exposure. All symptomatic children or asymptomatic children with blood leads greater than 80 μg per 100 ml should be treated immediately as potentially acute encephalopathy cases. Prompt institution of treatment basically consists of chelation therapy and restriction of parenteral fluids to basal requirements, with attention given to controlling convulsions,

should they arise, preventing hyperthermia, treating infection, and correcting metabolic derangements.

The chelates of choice are BAL [British antilewisite (dimercaprol)] and EDTA [ethylenediaminetetracetic acid (edathamil)] in combination. The combined use of BAL and EDTA is superior to either agent alone.[5] The recommended dosage of EDTA is 12.5 mg per kg every 4 hours, either intramuscularly or intravenously for five days. BAL is started first with 3-4 mg per kg being given every 4 hours intramuscularly for five days. After the course of therapy, if the blood lead level still has not come within normal limits, a second course of EDTA alone is given 3 to 10 days later. The dosage is 50 mg per kg per day intramuscularly for five days.

Major therapeutic use of EDTA is in the treatment of plumbism. If sodium EDTA is used, it must be given slowly intravenously because rapid infusion can produce hypocalcemic tetany. In contrast, calcium disodium EDTA can be administered intravenously in large doses with no untoward effects and no changes in the plasma or total body calcium levels. EDTA has a low toxicity but since it is excreted in the urine with 5% recoverable in 24 hours, levels may approach toxicity if there is any decreased renal function. Also there appears to be a direct nephrogenic effect on the lower nephrons with large doses. Thus, serial kidney function tests are advised.

BAL, like EDTA, is a poorly dissociable chelate, but unlike EDTA, it diffuses equally throughout body water. Peak blood levels are reached within 30 minutes and detoxification by the liver is completed in four hours. The most common side effects seen with BAL are a rise in systolic and diastolic blood pressures of up to 50 mm Hg, accompanied by a tachycardia. Capillary damage has also been reported, resulting in an increased hematocrit and decreased blood pH. Central nervous system effects include vomiting, convulsions, and tremors. In children a peculiar reaction is a fever which appears after the second or third injection and continues until the drug is stopped. Patients on BAL should not receive supplemental iron.

Institution of chelation therapy should be delayed until urine flow has been established. Because of the risks of precipitating encephalopathy in lethargic patients, all oral fluids should be withheld and parenteral fluids restricted to provide basal requirements and minimal estimates of replacement of deficits resulting from vomiting and dehydration.

When cerebral edema appears to threaten life, mannitol and dexamethasone (Decadron®) are recommended, in addition to prompt chelating therapy. A "neurosurgical dose" of dexamethasone, 10 mg intravenously at once and every four hours for three times will act promptly to decrease cerebral edema. Mannitol in a bolus of 1.5 gm per kg intravenously in 500 ml 5% dextrose in water will also relieve intracranial pressure and obviate the need for surgical decompression.

Penicillamine has been used in the outpatient treatment of the asymptomatic child with an increased blood lead level. Its advantage is that it can be taken orally, although there are many smaller children who cannot take oral medicines. The recommended dosage of penicillamine is 125 mg two to three times daily given over a four-week period.

It has been said many times that the first step to the treatment of plumbism is prevention. Obviously the logical place to start is in breaking the triad of childhood lead poisoning. This has been done previously by attacking the environment and by parent education. The easiest solution might be to break or redirect the childhood pica habit. The direct selectivity that some children exhibit for plaster could be diverted by making the plaster-lead paint complex unpalatable. Packaging a pungent, bitter tasting, odorless, colorless, nontoxic substance such as denatonium benzoate into an aerosol spray to be used on walls, window sills, and exteriors of lead-contaminated houses, would be an effective form of aversion therapy. Although some children may enjoy the bitter taste, the vast majority probably will not and will give up eating plaster for some other nonfood, hopefully nontoxic.

The aerosol may be made available by physician's prescription through hospitals and pharmacies. Ease of use and low cost would make it a most attractive alternative to the more costly and inconvenient solutions such as paneling walls, deleading houses, or relocating families.

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Fingernail Fetishism: Report of a Case Treated with Hypnosis

A J McSWEENY, MD, Janesville, Wis: *Am J Clin Hypnosis* 15:139–143 (Oct) 1972

Fetishism is a perversion which is characterized by sexual gratification by the sight, contact, or possession of some sexually associated object or part of the body. The fetishist commonly finds himself attracted to a woman's shoe, stockings, lingerie, or earrings. The sexually exciting object is specific for each individual affected; and a shoe fetishist, for example, does not become sexually aroused by earrings. The feminine foot or buttock are also among the more frequent fetish objects. Occasionally a particular odor becomes the source of erotic gratification. Sado-masochistic features and compulsive traits are often prominent among fetishists.

Complex formation, symbolization, and conditioning may play a role in the development of a fetish. The psychoanalytic theory of fetishism stresses the denial of intense castration anxiety of childhood. The fetish object symbolizes a "female penis" and thereby proves that women have not been castrated. In this way the fetishist avoids the evidence that there are human beings without a penis and that he could be one of them. Although this disorder has been extensively described, it remains extremely resistant to therapeutic modification.

A 23-year-old Caucasian draftsman recently came seeking help for a sexual problem. He could become sexually aroused and experience penile erection only by seeing or fantasizing the fingernails of a woman as they were being bitten by her. Women and the feminine genitalia were both frightening to the patient. When he spoke to a woman, he would sometimes have to excuse himself, leave the area and vomit!

Over the course of several interviews, it became apparent to the patient that the fingernail fetish established that his sexual object was not his mother. His mother's fingernails were always well manicured, long, slender, and carefully polished. The woman was tall and slender. He was particularly disturbed by slender women and by long, narrow, well manicured fingernails.

Although the patient developed much insight into his problems over the course of several psychotherapeutic interviews, no symptomatic improvement was apparent. It was proposed to him that the use of hypnosis might be helpful in producing some behavioral changes. The patient was then presented with a few hypnotic suggestions which were actually a restatement of some of his own thoughts and formulations from previous interviews: (a) Not all women are your mother. (b) It is wholesome, healthy, natural, and not sinful for a man to be attracted to a woman. (c) Women are usually not hostile to men and are usually receptive to men. (d) The feminine sex organs are not dangerous and need not be frightening or repugnant. Subsequent events confirmed that the patient had been very receptive to these therapeutic thoughts and that their impact was greatly facilitated by the trance state.

A few days after this hypnotic session, the patient began a dating relationship with a student nurse. He did not develop his usual disgust reaction. He continued seeing the young lady; and over a period of weeks, all feelings of guilt and anxiety subsided. During a subsequent hypnotic session, it was suggested that he would feel sexually aroused by his girl friend. Soon thereafter he experienced penile erection while kissing her and he "felt good afterward." He began to use his new girl friend as a masturbation fantasy and discarded the practice of imagining fingernails. Later she masturbated him manually, and he began having dreams of sexual intercourse with her. Subsequently, the couple became engaged to be married and began having sexual intercourse. He reported that he had not achieved ejaculation by seeing or fantasizing nail biting for a period of two months. The patient asked his fiancee to keep her fingernails clipped short because he felt more at ease with her and was less inclined to think of his mother. He considered asking her to wear soft mittens during their sexual encounters. Shortly before terminating therapy, the patient was surprised to find that many young women looked attractive to him. He particularly liked "hefty girls." At the present time the couple has been married for three years.

Although fetishism is generally considered a difficult therapeutic challenge, this patient did respond to treatment with hypnosis. The basic treatment strategy was a displacement of cathexis. A path was cleared for displacement of libidinal energy from the patient's sexual conflicts and symptoms. Subsequently, when he was hypnotically assisted to redirect his libidinal energy into the new route, he was able to invest regression of the presenting symptoms, real improvement in mental functioning, and improved reality adjustment. The favorable results indicate that further study of the use of hypnosis in the treatment of fetishism is warranted. □

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he vaginal vault each day for ten days and oral dosage is reduced to two 250-mg. tab- daily during the ten-day course of treat- nt. Do not use the vaginal inserts as the sole n of therapy. *In the male:* Prescribe Flagyl when trichomonads are demonstrated in urogenital tract, one 250-mg. tablet two es daily for ten days. Flagyl should be taken both partners over the same ten-day period en it is prescribed for the male in conjunc- with the treatment of his female partner.

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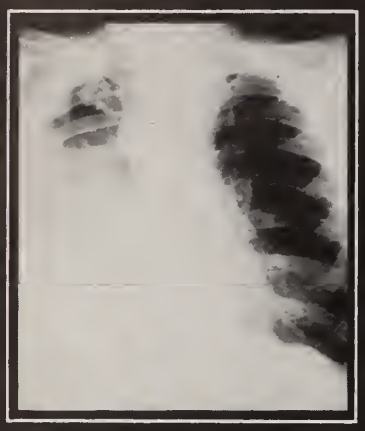

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FROM THE PRESIDENT

Another Four Letter Word – PSRO

CULMINATING FOUR YEARS of legislative hearings, major revisions in Medicare and Medicaid were enacted under Public Law 92-603. These changes are extensive and far-reaching and cover areas relating to eligibility, medical liability, change in definition of skilled nursing facilities, changes relating to payments and benefits both to patients and physicians, as well as professional standards review organizations. Increasing correlation between Medicare and Medicaid programs can be identified and might have medical implications as more experience is gained with these two programs.

The governmental alphabetic jargon produced the letters PSRO under the Social Security amendments. This mandated program relating to review of patient care is the most significant legislative directive since the original Medicare-Medicaid legislation. Guised under the phrase of quality, it is in reality a cost-control mechanism affecting our ability to exercise independent medical judgment for the patient's benefit.

Medicine accepts the challenge of the new law as physicians in the past have led the way in assuring quality of care for their patients. This has been our tradition and our code of ethics. We will further refine our efforts to "apply professionally developed norms of care, diagnoses and treatment . . . as principal points of evaluation and review."

Fully recognizing the inherent dangers of medical standard setting by the government, a new emerging bureaucracy, increased "health-care" costs generated from HEW, and more usage of physicians' time for government paper-work, the Medical Society is committed to cooperation and implementation—but not regulation. We must be watchful of the phrase "in accordance with the regulations of the secretary."

Each member of this great state organization must become aware of his personal responsibility as this law relates to medical practice. Forthcoming rules and regulations will apply to all areas and all physicians. Your knowledge, interest, and hard work will make it possible to maintain our tradition of quality medical care to our citizens. We must not abdicate our role as leaders in this area.

Our commitment to quality is our challenge. We will respond accordingly to this four letter word — PSRO.

G. J. Derus M.D.

WPS' HMP Draws National Attention

WPS EXPLAINS ITS HMP
Seated: Roger Graham, WPS staffer; John Greer, Arkansas Blue Cross and Blue Shield; Laurence Crocker, MD, Madison. Standing: Larry Morris, National Association of Blue Shield Plans; Joe Woosley, Blue Cross Association.

The pathfinding Health Maintenance Plan (HMP) started last fall by WPS, the State Medical Society's Blue Shield plan, has attracted national attention. This summer the national associations of both Blue Cross and Blue Shield asked WPS to explain to other Blue plans how HMP works.

The result was a day and a half national seminar in Chicago attended by over 40 plans from across the country. Some 150 health insurance plan presidents, physicians, and other insurance professionals attended.

The HMP approach was started by WPS in Wild Rose in 1971. Today WPS has HMPs in seven Wisconsin counties where some 746 physicians are serving 19,650 subscribers. This represents over 95 percent participation by physicians in those counties.

The HMP concept combines two financing approaches: capitation and fee-for-service. The plan pays for primary care (office visits, lab charges, etc.) as well as major medical expenses. Each month physicians are automatically prepaid for handling the health maintenance of subscribers.

At the Chicago meeting a representative of Arkansas Blue Cross and Blue Shield said that group is developing an HMP on the WPS model. The Arkansas group has made three visits to Madison in the past to study the concept.

Along with eight WPS staff members Dane County Medical Society president Laurence Crocker, MD, Madison, participated in the seminar. Last year he was chairman of the committee that helped provide physician input when an HMP was being developed for Dane County.

Dr. Crocker noted that there was much discussion about the plan before it was agreed to by the county society. He said aspects of the plan are still being discussed. For example, there has been debate about what sort of coverage is appropriate for periodic health examinations to insure that the program is really health *maintainance* and not "just another sickness or crisis-oriented insurance program."

Also at the seminar Jim Deblack, Advance Transformer Company, Monroe, told how he viewed the plan from the standpoint of a company providing health-care coverage for its employees.

He said the company was sold on the WPS plan because of the broad health benefits it offered and the HMP approach of having "the physician take a management approach to control the cost of health care." □

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Education in the '70's—WAP

Professionals as professionals—be they physicians, lawyers or members of any other recognized profession—have some common interests. This is the rationale behind the Wisconsin Association of Professions (WAP).

Every year WAP invites all Wisconsin professionals to an annual congress which focuses on the outlook in a particular professional area. This year discussions on "Education in the '70's" will be held Saturday, Sept. 29, at the Holiday Inn, Eau Claire.

Registration begins at 8:30 a.m. with the program starting at 9:30 a.m. Mrs. Barbara Thompson, state superintendent of public instruction, will lead off with a discussion of "Elementary and Secondary Preparation."

"Career Guidance 'Counseling and the Counselors'" will be discussed by Robert Torkelson, AIA-PE, past president of WAP.

Eugene Lehrmann, state vocational director, will speak on "Vocational, Technical, and Adult Education Also An Aid to the Professions."

Leonard Haas, president-provost of University of Wisconsin-Eau Claire, will address the group on "The University: Handmaiden for the Professions."

Following a luncheon a panel and audience discussion of the morning session concerning all aspects of education and careers will

Hand in Glove: Peer Review, Education

Peer review and continuing medical education go hand in glove. The State Medical Society's concern with both has grown over the past year with its involvement in Wisconsin Health Care Review, Inc. Another facet of that involvement appeared to be emerging last month.

Roy Ragatz, who was assistant secretary of the State Medical Society from 1944 until 1967, has accepted an assignment as a speical project coordinator to help the Society's Commission on Scientific Medicine initiate a statewide coordinated program of continuing medical education. The idea is to unite many diverse medical programs and representatives into one effort that will be beneficial to physicians throughout the state. This includes the State Medical Society's participation in American Medical Association programs leading to the Physician Recognition Award.

Mr. Ragatz has moved his office to State Medical Society headquarters, including that of the Interstate Postgraduate Medical Association, of which he has been executive director for about 20 years. This national association, directed by physicians from Iowa, Wisconsin and Illinois, has as its primary function the development and presentation of an annual scientific program with special appeal for primary-care practitioners.

The project Mr. Ragatz is aiding will draw together not only scientific programs but also education about tools such as patient-care appraisal and the problem-oriented record.

It is expected that a special coordinating group will be created to do this. Several Society committees and commissions will no doubt be represented along with the medical schools, Regional Medical Programs, Wisconsin Health Care Review, Inc., and specialty societies.

The project's first goal will be to develop and implement accreditation of continuing medical education programs offered by hospitals and other organizations and institutions in Wisconsin.

Studies on how best to develop programs of patient-care appraisal are now being carried out by Thomas Meyer, MD, Madison, in four hospitals in Edgerton, Watertown, Madison, and Prairie du Sac-Sauk City. It is expected that as programs in these hospitals are developed, personnel there may gain enough expertise to go out and help other hospitals around the state set up similar efforts.

Dr. Meyer's project is directed from the Department of Continuing Medical Education at the University of Wisconsin Extension in conjunction with Paul Tracy, MD, Madison, of the Wisconsin Regional Medical Program. It has been underway for six months and is expected to continue for another year. □

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be held. Adjournment is set for 3:00 p.m.

Advance registration fees for members and guests: $7.50 per person; at the door: $10.00 per person. Contact: Wisconsin Association of Professions, P.O. Box 1109, Madison, Wis. 53701.

WAP is comprised of members from the following professional associations: architects, attorneys, physicians, teachers, pharmacists, engineers, dentists, veterinarians, and certified public accountants.

The non-profit corporation was created to provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare. □

Loyal Friend

One of medicine's great friends and loyal supporters retired last month from the staff of the State Medical Society.

Thomas J. Doran, who joined the Society in 1945, retired July 31. Always interested in people, Mr. Doran came to the Society from the City of Madison welfare department.

There he had worked very closely with the physicians of Dane County in developing medical-care delivery on a "free choice" basis for welfare recipients. His administration was noted for combining sound businesses and decent humanitarianism—a trait that continued in his years with the Society. Some of his finest friends are those who were involved at one time or another in a grievance case which he was handling for that Society committee.

Mr. Doran was the first claims director for the Society's health insurance division, Wisconsin Physicians Service (WPS), as that program got off the ground in 1946. Then in 1966 when Title XIX came into being, he took over direction of that claims activity. He became assistant to the executive director of WPS in 1972.

HONORED AT RETIREMENT
Council president E. J. Nordby, MD, Madison, presents book of letters of appreciation to Thomas J. Doran, Society staff member, who retired July 31.

He has long been active in the Madison community and served ten years on the city's police and fire commission, two years as its chairman. He has also been a member of state government committees, such as the committee on problems of the aged of the Wisconsin Legislative Council and the Governor's committee on employment of the physically handicapped.

He met his wife, the former Rosamond Gilchrist, in his home town of Janesville, where both worked for the Rock County welfare department. Mr. Doran's interest in this work led him next to Darlington, where he was relief director for LaFayette County from 1934 to 1938.

While there, the LaFayette County Medical Society set up a countywide health clinic. Mr. Doran was business administrator of the clinic which, among other things, gave tuberculosis tests to school children and provided physicians with "family trees" of those who had tested positive for the disease.

Mrs. Doran is well known for her work as director of Madison General Hospital's medical social service department from 1956 until 1969 as well as her activity in other areas of welfare work. □

STAT

New Examiners

Governor Lucey has appointed Mark T. O'Meara, MD, La Crosse, to the Medical Examining Board. John W. Rupel, MD, Marshfield, was reappointed to the board. Dr. O'Meara replaces Adolf Gundersen, MD, La Crosse, whose term has expired.

Dr. O'Meara, a surgeon, is president of the board of directors of the Skemp-Grandview Clinic in La Crosse. Dr. Rupel, first appointed to the board in 1972, is an obstetrician at the Marshfield Clinic.

Board members serve staggered four-year terms. The eight-member board operates within the State Department of Regulation and Licensing and is responsible for examination, registration, and enforcement actions for medical and osteopathic physicians, physical therapists, and podiatrists.

■

Becoming Successful

Throughout most of this century the Christmas Seal has decorated much of America's mail in December. At the beginning, the money from sale of seals went toward the fight against tuberculosis. As that fight edged toward success and pollution became a more pressing problem, the organization behind the Christmas Seal changed its name. The National Tuberculosis Association became the National Tuberculosis and Respiratory Disease Association. Recently that somewhat cumbersome handle was exchanged for one that reflects the organ of concern rather than its potential diseases. However, the National Lung Association still identifies itself as "Your Christmas Seal Association."

■

With the Majority

The Wisconsin Legislature is moving to put our state with the majority of states having a .10 or lower blood alcohol concentration level as proof of intoxication. On June 27 the Assembly passed the bill by a 94-3 margin and sent it to the Senate. The bill was part of the Governor's legislative highway safety program.

According to John Radcliffe, the Governor's highway safety coordinator, "persons with .15 blood alcohol level have 25 times more chance of causing auto crashes than if they had not been drinking.

Dr. Helliesen

Even at .10 drivers' chances of crash involvement is at least six times as great as that of non-drinking drivers." For a number of years the State Medical Society has endorsed the idea of setting the presumption for intoxication at .10.

■

Democratic Control

With Gov. Patrick Lucey's four new appointments to the State Board of Health and Social Services, his appointees will have control of the board.

Awaiting Senate confirmation are the appointments of La Crosse pediatrician Per J. Helliesen, MD; Mrs. Laurence DeWitt, an Oconto laboratory executive; John Slaby, a Phillips attorney; and attorney John Niemisto, a member of the Red Cliff Chippewa tribe.

They succeed Harold J. Kief, MD, Fond du Lac; Mrs. Charles Vaughn, Madison; and Franklin Walsh, Walworth County. All but Dr. Helliesen would have terms expiring in 1979; Dr. Helliesen's term expires in 1977. He was appointed to fill the position of Robert Spears, Washburn, whose term expired in 1971. Previously Mrs. Dolly Kappeler, Odanah, was named to the post, but her name was later withdrawn from Senate consideration.

The nine-member board directs the Department of Health and Social Services through the secretary which it appoints. Wilbur J. Schmidt is the current secretary.

Gov. Lucey has proposed that the secretary be appointed by the governor and that the board act in an advisory role. The fate of that proposal is linked to the Governor's cabinet government bill which has had heavy opposition in the democratically controlled Assembly.

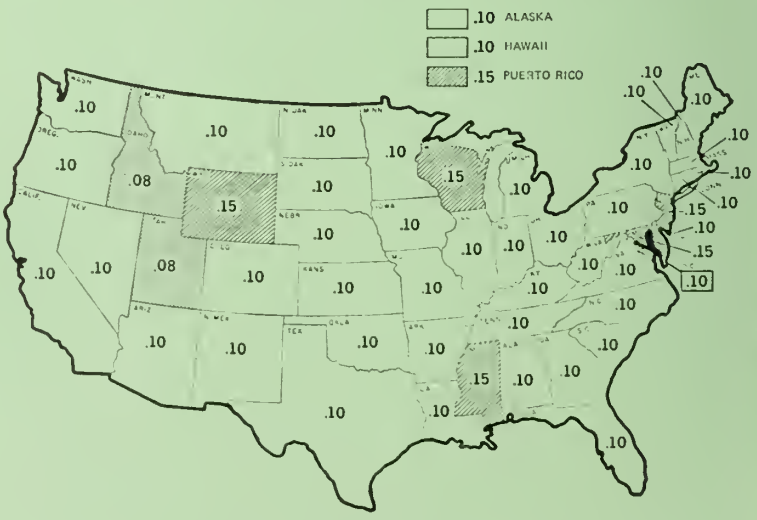
■

Immunization Month

Apathy seems to be taking over parental attitudes toward childhood immunization for such formerly dread diseases as measles, rubella, mumps, and whooping cough. George Handy, MD, state health officer, reports his department found that 41 percent of Wisconsin two-year-olds did not get the polio immunization series last year.

To counteract this, a dozen state and voluntary organizations (including the State Medical Society) have formed the Interorganizational Committee on Immunization. Among other things, the Committee proposes that September be "Immunization Month" in Wisconsin. Immunization of preschool children will be the major goal. □

BLOOD ALCOHOL CONCENTRATION LAWS



A CENTURY OF SERVICE TO THE WISCONSIN MEDICAL JOURNAL. Members of the Editorial Board and the Medical Editor of the WISCONSIN MEDICAL JOURNAL, the State Medical Society's official publication, were honored by the Council at its evening dinner meeting July 14 in Madison. The occasion recognized the 100 years of service by the five Board members and the Medical Editor. They're shown above, left to right: David W. Ovitt, MD, Milwaukee; Leslie G. Kindschi, MD, Monroe; Mrs. Mary Angell, Madison, assistant managing editor; Victor S. Falk, MD, Edgerton, medical editor; Gerald J. Derus, MD, Madison, State Medical Society president who made the presentation of individual bronze plaques to each; Garrett A. Cooper, MD, Madison; and Merlyn C. F. Lindert, MD, Milwaukee. The fifth member of the Board, Melvin F. Huth, MD, Baraboo, was unable to attend. Doctor Ovitt has the longest tenure, 22 years; Doctor Cooper, 20; Doctor Falk, 20 (9 as Editorial Board member, 11 as Medical Editor); Doctors Kindschi and Huth, 13; and Doctor Lindert, 12. Doctor Derus noted that their service to the Journal has been carried out almost as a daily routine without the usual commitment of one or two meetings a year. Their collective opinions have guided and strengthened the Journal's character to a position of high esteem not only among Society members but also among the entire medical community of the state and nation.

An Ombudsman for the Ombudsman?

Do we need an ombudsman for the ombudsman?

After a month of working with Lt. Gov. Martin Schreiber trying to arrange medical review services for the nursing home ombudsman program in his office, State Medical Society officials were brought up short in mid-June by a newspaper blast on the subject.

The *Madison Capital Times* blared "Schreiber Charges Cheating by Doctors," always a good eye-catcher. The *Milwaukee Journal* somewhat more sedately headlined the story "Quickie Medical Tests at Nursing Homes Hit."

Both reviewed a letter the Lt. Governor had sent to Society secretary Earl Thayer, although Mr. Thayer had not yet received it. In it, Mr. Schreiber said "a number of complaints" had been received about physicians receiving Medicare and Medicaid reimbursements for physical examinations at nursing homes without actually doing the exams.

The publicity was even more perplexing because the month-long discussions among the staffs of the Medical Society, the ombudsman in the Lt. Governor's office, and Wisconsin Health Care Review, Inc., (WHCRI) had yet to produce a single specific example of such abuses, despite repeated Medical Society requests.

A month after the story hit the papers, additional Medical Society requests had still not dislodged specific information as to the nature of problems or complaints.

As time passed, the Medical Society of Milwaukee County checked what information it could glean in its area, but failed to turn up a single instance to match Lt. Gov. Schreiber's allegations.

The Milwaukee Society's exasperation with the matter was expressed in a July 16 letter to the Lt. Governor from executive secretary Michael McManus who said: "A review of all complaints received by the Milwaukee ombudsman office at the time of your letter to the State Medical Society revealed that not a single formal complaint investigated by the Milwaukee ombudsman office related to the type of abuse which you cited."

The State Medical Society's Council at its meeting in Madison July 14 again reaffirmed the Society's willingness to work on the problem, if indeed a problem exists.

This would be in addition to work under a proposed contract between the State Department of Health and Social Services and WHCRI to review Medicaid patients in Wisconsin nursing homes (see July GREEN SHEET).

Webster defines an ombudsman as "a government official appointed to receive and investigate complaints made by individuals against

continued on next page

No Laughing Matter

Scores of jokes have been made about the Kickapoo Valley, mainly because of its name. But the lack of physicians in the sparsely populated area is no laughing matter.

A year ago the fledgling National Health Service Corps designated the valley for MD help in the form of National Health Service Corps (NHSC) physicians. A physician was also assigned to the former Indian reservation of Menominee County. The hope was to not only relieve the immediate physician shortage in these two areas but also that the assigned physicians would stay on after their tours of duty as a health-care nucleus for the areas.

The Menominee assignment of Michael J. Reinardy, MD, a family physician, is working out well (see March GREEN SHEET). However, the two young physicians sent to the Kickapoo left less than three months after their arrival.

Last month two replacements finally arrived in the valley,* but last year's false start prompted Wisconsin's AMA delegation to introduce a resolution on NHSC at the AMA's annual meeting in June. It asked for development of "personnel selection and screening procedures designed to assure the proper matching of recruited physicians to the needs and desires of the communities to which they may be assigned."

The resolution was passed by the AMA House of Delegates with minor wording changes which asked AMA-NHSC cooperation in developing the matching procedures.

At the same meeting the Wisconsin delegation also presented resolutions asking for nationwide support of *Current Procedural Terminology* (CPT), third edition, and the reactivation of the AMA Committee on Medical Aspects of Automotive Safety.

The CPT resolution was passed in somewhat modified form to include wording from similar resolutions from three other states. The AMA House of Delegates rejected the idea of reactivating the six-member automotive safety committee abolished last fall. At that time it was announced that the committee's duties would be shifted elsewhere in the AMA structure. The delegates' sentiments were to wait and see how the new arrangement works before making any further changes.

The work of two outstanding physicians was cited by the AMA House of Delegates at Wisconsin's request. The first American physician in space, Joseph P. Kerwin of the Skylab 1 crew, was commended for his "efforts in the pursuit of scientific knowledge." Hans H. F. Reese, MD, an AMA delegate from 1946 to 1956 was memorialized by the delegates. The emeritus professor of neurology at the University of Wisconsin Medical School died June 23.

Much of the delegates time and attention at the meeting in New York June 24-28 was directed to that now familiar anagram, PSRO (Professional Standards Review Organization).

The emerging government role in peer review was the topic of two reports by the Board of Trustees and seven resolutions from the states of California, Oklahoma, and Texas.

Texas called for efforts to repeal the 1972 PSRO law. California asked for "appropriate amendments" to the law. Oklahoma requested AMA resistance to PSRO.

However, the outcome was a continuation of AMA's "cooperative leadership" in PSRO. The delegates agreed that changes in the PSRO law might be necessary in the future, if the mandated activity seems to be undermining the quality of patient care.

The inaugural address of incoming AMA president Russell B. Roth, MD, of Erie, Pa., was in tune with this approach. He emphasized the need for the profession to work with government in its attempts to solve problems in the health-care area.

The medical society is the vehicle for this, he said, along with efforts in every other area of concern for the practicing physician, from graduate medical education to the organization of the health-care delivery system. □

*Dennis J. Nolan, MD, and Glenn Golbus, MD. Both have just completed internships: Dr. Nolan in Portland, Ore., and Dr. Golbus at Milwaukee County General Hospital.

FOR TEENAGERS, HEALTH EDUCATORS

Work Week - Health Set for Oct. 2-4

"Getting It Together on Health," a program aimed at teenagers and health educators, will be this year's Wisconsin Work Week of Health, October 2-4 at State Medical Society headquarters in Madison.

The day-long programs will be a mixture of short talks by experts on problems of special concern for teenagers followed by small group discussions involving experts, teachers and teenagers.

Among topics discussed will be abortion, venereal disease, drinking, drugs, and personal relationships.

It is hoped the programs will encourage communication between health educators and their students and be the basis for more work in the home communities. Members of the Woman's Auxiliary to the State Medical Society were instrumental in planning the program and are working to encourage local schools to send teachers and students to it.

Ombudsman *continued*

abuses or capricious acts of public officials." As the summer passes and the nursing home ombudsman's investigations fail to materialize, it increasingly appears that Wisconsin physicians and the public may need an ombudsman for the ombudsman.

Other Council Actions

In addition to grappling with the nursing home ombudsman problem (see above), the State Medical Society's Council dispatched a long list of other items at its summer meeting, July 14-15. Among them were:

- Approval of a joint study with the Wisconsin Pharmaceutical Association on creation of a joint committee of physicians and pharmacists to study the feasibility of establishment of a formulary of drugs which might be regarded as chemically or therapeutically equivalent.
- Termination of the parent Commission on State Departments at the recommendation of the Planning Committee.
- Approval of the appointment of Edwin Hirsch, MD, Milwaukee, to the State Medical Society's Committee on Peer Review. Dr. Hirsch is associate dean for student affairs at the Medical College of Wisconsin.
- Acceptance with regret the resignation of L. O. Graf from the Board of Trustees of CESF. □

Anatomy Exhibit at Museum

A special summer exhibit at the Museum of Medical Progress in Prairie du Chien is a display of anatomy specimens from the University of Wisconsin Medical School and the Medical College of Wisconsin.

The exhibit shows actual organs and fetuses in various stages of development, including abnormal births. Plans call for a permanent exhibit to be built with medical school help, showing organs as they are when normal and when in various stages of disease.

Helping set up the exhibit and explain it to visitors is Robert Smith, a graduate student in anatomy at the Medical College of Wisconsin. He is spending the summer in Prairie du Chien, dividing his time between the hospital there and the Museum.

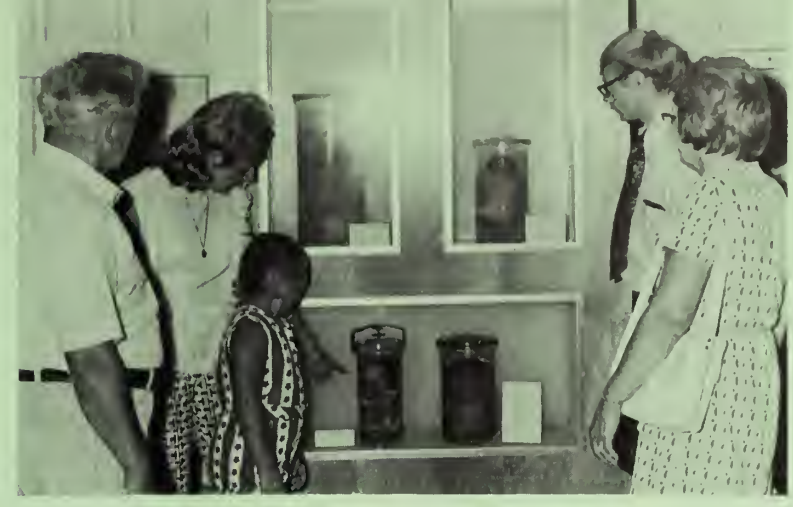
His work is being done under a grant from Consultants in Pathology of Beaver Dam.

The anatomy exhibit supplements the large exhibit, "Maintaining Life in a Hostile Environment," recently received from the U.S. Office of Emergency Preparedness. That exhibit shows films and slides of natural disasters and preventive measures that can be taken.

The Museum also features medical history of Wisconsin, the light-up "Transparent Twins" that explain how the body works and a collection of medical medallions and original paintings by Aaron Bohrod on medical subjects.

Summer hours of the museum are 9 a.m. to 9 p.m. seven days a week.

The Museum is owned and operated by the State Medical Society's Charitable, Educational and Scientific Foundation. □



Some of the anatomy specimens on display at the Museum of Medical Progress are explained by Robert Smith (right), the Museum's summer extern.

New Generation: Council, Officers

To many close followers of the State Medical Society's leadership, it has seemed lately that the councilors and officers have been growing increasingly younger. It's not just an illusion.

Some fast figuring by the Society staff has turned up 53 years as the average age of today's Council (including all voting members). Gerald J. Derus, MD, Madison, is one of the Society's youngest presidents. Since early in this century Society presidents have tended to be over 50. Dr. Derus was 46 when he took office.

Three of the newest faces among the leadership are of Dr. Derus' generation. All were elected in March at the Society's annual meeting.

Twelfth district councilor Gregory Inda, MD, was born Dec. 23, 1929, in Milwaukee. He graduated from Marquette University School of Medicine in 1954 and took an internship at Queen of Angels Hospital in Los Angeles. After a residency at the Wood Veterans Administration Center and two years in military service, he began the practice of internal medicine in Milwaukee.

Sixth district councilor John R. McKenzie, MD, Neenah, was born March 17, 1929, in Helena, Mont. He graduated from Marquette University School of Medicine in 1955 and took an internship at Milwaukee's Misericordia Hospital. He practiced general medicine in Rice Lake for six years and then returned to Milwaukee to train in radiology at County General Hospital.

The new vice-speaker of the House of Delegates, Patricia J. Stuff, MD, a Bonduel family physician, was born May 11, 1929, in Ogle County, Ill. She graduated from Woman's Medical College of Pennsylvania in 1955 and took an internship at Chicago St. Luke's Hospital. After further training at Sacred Heart Hospital in Yankton, S. D., she came to the Bonduel Clinic. Her husband, W. W. Grover, Jr., MD, also is a family physician. Dr. Stuff is the State Medical Society's first woman officer in its 132-year history. □

Dr. McKenzie

Dr. Stuff

Dr. Inda

Emphasis on Indian Health Careers

DR. REINARDY AND HIS STUDENT CLERKS

INDIAN STUDENT WORKING AT SHAWANO COMMUNITY HOSPITAL

One way to beef up the nearly nonexistent health manpower in Menominee County is by getting the area's students interested in a health career there.

To do this a special clerkship was set up this summer by the State Medical Society's Charitable, Educational and Scientific Foundation (CESF) in cooperation with Shawano High School.

All three of the student clerks are Native Americans. One, Carol Cree, Gresham, is working at Shawano Community Hospital under the direction of Don Johnson, the administrator, and Mrs. Louise Blackman, head nurse. She is the daughter of a missionary at Stockbridge Indian Reservation and plans to become an evangelist with the Indians. She wants a health background for this work.

The other two are working with Michael J. Reinardy, MD, the National Health Service Corps physician at the Neopit Community Center. Stewart Boivin, Neopit, wants to be a surgeon; Rae Ellen Penass, Keshena, hopes to become a nurse.

All three students will return to Shawano High School in the fall. They are working for ten weeks and receive a grant from CESF.

The money for the project originally came from a gift of the estate of Ruth Coe, RN, Madison, who was interested in helping Indian students in Menominee County toward health careers. □

Sculpture Dedication at Museum Sept. 8

A tribute to 300 years of medicine in Wisconsin will be dedicated at the Museum of Medical Progress in Prairie du Chien, Sept. 8.

With metal and medical instruments collected over the years from physicians across the state, Prairie du Chien artist Dave Myers created a 24-foot high free-form sculpture now standing on the Museum lawn. Funds for the work included individual contributions to the State Medical Society's Charitable, Educational and Scientific Foundation (CESF) and special grants from the Wisconsin Arts Council.

The dedicatory luncheon and program will be hosted by the Aesculapian Society (CESF's Museum guild). Lunch will be served at 1 p.m. at Giesler's Blue Heaven, Prairie du Chien. The dedication will begin at 2:30 p.m. on the Museum lawn. Luncheon reservations may be made through CESF at State Medical Society headquarters in Madison.

Calling Air Medic

A new answer for patients needing long-distance, rapid ambulance service has been developed in California.

Air Medic, fully equipped air ambulances, are on tap day and night. By making a toll free call to Air Medic, aircraft can be requested for almost any airport in the U.S. They are fully equipped and staffed by Air Medic.

Although Air Medic is based in California, it operates nationwide. For the local toll free number, simply call the information number 800-555-1212 and ask for Air Medic.

Air Medic is unique in that it is a single agency arranging and coordinating air ambulance flights nationwide. It dispatches aircraft ranging from single engine to the most modern jets. Air Medic's standing operating orders call for a pilot, co-pilot and licensed medical professional to accompany all flights. All aircraft must be equipped to Air Medic's standards. □

MD Productivity, Seminar Subject

The education of the physician in the delegation of some portion of his practice to allied health personnel, or "physician extenders," will be provided at a seminar Saturday, Nov. 10, in Marshfield. "Physician Extension Techniques" is being sponsored by the Marshfield Clinic Foundation for Medical Research and Education. Seminar will be held at The Theater, UW-Wood County Center. □

ABBOTT

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CHLORVYNOL)

ef Summary

ations—Placidyl (ethchlorvynol) is indicated ort-term hypnotic therapy in the management somnia.

aindications—Drug hypersensitivity and por-a.

ings—Not recommended during the first and d trimester of pregnancy. Caution patients ossible combined exaggerated effects with ol, barbiturates, tranquilizers or other CNS ssants. Exaggerated effects might result in ng of vision, paralysis of accommodation and und hypnosis. Caution patients concerning g a motor vehicle, operating machinery, or hazardous operations requiring alertness af-aking the drug. Administer with caution to nts with suicidal tendencies and do not pre-e large quantities of the drug. Adjustment of osage of oral anticoagulants might be neces-when beginning ethchlorvynol therapy, during by, or after stopping therapy. This drug is ecommended for use in children. PLACIDYL THE POTENTIAL FOR THE DEVELOPMENT SYCHOLOGICAL AND PHYSICAL DEPEND-. INSTANCES OF SEVERE WITHDRAWAL TOMS, INCLUDING CONVULSIONS AND RIUM CLINICALLY SIMILAR TO THOSE SEEN BARBITURATES, HAVE BEEN REPORTED ATIENTS TAKING REGULAR DOSES AS LOW 000 MG. PER DAY OVER A PERIOD OF WHEN THE DRUG WAS SUDDENLY DIS-INUED. PROLONGED ADMINISTRATION OF DRUG IS NOT RECOMMENDED. Addiction-patients or those who are likely to increase ies of the drug on their own initiative should bserved for evidence of signs or symptoms may indicate possible early withdrawal or ience symptoms. Signs and symptoms asso-d with withdrawal and abstinence include un-anxiety, tremor, ataxia, slurring of speech, ory loss, perceptual distortions, irritability, ion and delirium. Other less well defined and symptoms, not necessarily due to with-l and abstinence, may include anorexia, nau-or vomiting, weakness, dizziness, sweating, e twitching and weight loss. Abrupt discon-ice of Placidyl following prolonged overdos-ay result in convulsions and delirium.

utions—Toxic amblyopia has been reported long-term continuous use of ethchlorvynol. nent visual defects have been observed, al-h amblyopia has improved after discontinua-of the drug. Drug dosage should be limited derly and debilitated patients to the smallest ve amount. If pain is present, this drug d only be given if insomnia persists after s controlled with analgesics. Caution is ad-in prescribing the drug for patients who are treated with either MAO inhibitors or anti-ssants. Transient delirium has been reported he combination of Placidyl and amitryptyline. dosage should be reduced if prescribed for ts receiving MAO inhibitors or antidepres-Caution should be exercised in patients mpaired hepatic or renal function. Patients espond unpredictably to barbiturates or alco-r who exhibit excitement and release of inhi-in association with such agents, may also in this way to Placidyl. Rarely, patients may t symptoms suggestive of an unusual sus-ility to the drug; such as prolonged hypnosis, nd muscular weakness, excitement, hysteria, cope without marked hypotension. Transient ess or ataxia may occur.

se Reactions—Hypotension, nausea or vom-gastric upset, aftertaste, blurring of vision, ess, facial numbness, and allergic reaction d by urticaria have been reported following yl administration. Mild "hangover" and symp-of mild excitation have occurred in some s. There have been rare reports of cholestatic ce occurring in patients taking ethchlorvynol. cases of thrombocytopenia have been re-in patients receiving ethchlorvynol. 302430R

Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often associated with emotional disturbance. Emotional problems might be the cause . . . or the effect. In time that can be determined. But tonight, one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

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Placidyl®
(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Su[illegible] 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 [illegible] (equivalent to 3.5 mg. neomycin base); special white petrola[illegible] q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil pac[illegible]

Wellcome

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Minutes of Special Council Meeting

State Medical Society of Wisconsin — Madison, May 10, 1973

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:45 p.m. at the State Medical Society.

Voting members present: Doctors JJFoley, Nordby, Beilman, Huth, Edwards, Smejkal, Mauthe, McKenzie, Rohde, Heinen, Lewis, Manz, Doyle, Inda, Schmidt, Williams; President Derus and Speaker Hamlin.

Members of Commission on Medical Care Plans: Doctors Dessloch, Krohn, Mason, Casper, Goldstein, Garman, Natoli, Smith, Wright, Stahmer, Rueckert, Sprague, Finn; Messrs. Brickson, Pauls and Vogel.

Others: President-elect Dettmann; Vice-speaker Stuff; AMA alternate delegate Kief; Messrs. Thayer, Koenig, Maroney, Graham, Bontrager, Doran, Brodersen, Feuling, McIntyre, LaBissoniere, Johnson, Brower, Reynolds, Murphy, Kluwin, Horton, Gill; Mrs. Anderson and Miss Pyre.

2. Oath of Office

The oath of office was administered by the chairman to Gregory Inda, MD, councilor from the twelfth district.

3. Approval of Minutes

On motion of Doctors Huth-Mauthe, carried, minutes of March 24, 25 and 27, 1973, Council meetings were approved.

4. Proposed Reorganization of WPS

The Council met to consider reorganization of WPS pursuant to action of the House of Delegates as follows:

"*Resolved,* That the House of Delegates authorize the reorganization of WPS by the Council and its Commission on Medical Care Plans under Chapter 611 of the Statutes as a stock insurance corporation, and the transfer to such corporation of the assets and business of WPS, including the assumption of all WPS liabilities.

It was pointed out that this action left to the Council the discretion whether or when to proceed, as well as the determination of a format which will assure the continuing operation of WPS consistent with policies of the Council and the House of Delegates. It was further noted that where a corporation owns all of the stock of another corporation, a common practice is for the board of the owner corporation to vote such stock by majority vote as the collective agent of the owner. Under this practice the Council would vote the stock of the insurance corporation in such matters as the election of directors, the adoption, amendment or repeal of a bylaw, or the amendment of corporate articles.

The Council was provided background information on decisions that must be made prior to final preparation and submission to the Commissioner of Insurance of proposed Articles, Bylaws, and Application for a Certificate of Incorporation and a Certificate of Authority, together with recommendations from the Executive Committee of the Commission on Medical Care Plans which had considered essentially the same information at a meeting on April 19, and from the Executive Committee of the Council which met with members of the Commission the morning of the Council meeting.

Council action as to each of these matters was as follows:

A. Incorporator and Registered Agent

On motion of Doctors Derus-Schmidt, carried, the State Medical Society was named as the incorporator, and the Secretary of the Society to act as the registered agent.

B. Name of Insurance Corporation

On motion of Doctors Edwards-Doyle, carried, the Council adopted the corporate name of "Wisconsin Physicians Service Insurance Corporation."

C. Size and Composition of the Board of Directors; D. Designation of Initial Board

After considerable discussion of recommendations from the Executive Committees of the Commission and the Council, this action was taken:

On motion of Doctors Derus-Beilman, carried, the initial board of directors is to consist of the present members of the Commission on Medical Care Plans and the chief executive officer, whatever his title, (a total of 24) to serve until the first annual meeting of the corporation; provided further that thereafter a board of 18 will be established, including not less than three councilors and up to one-third public members, and that a nominating committee appointed by the Chairman of the Council convene three months prior to the termination of the first year of business to make recommendations to the Council.

E. Compensation of Directors

On motion of Doctors Edwards-Manz, carried, the Council approved reimbursement of non-employed directors at $100 per meeting (board or committee) plus incurred expenses.

F. Corporate Offices

On motion of Doctors Beilman-Edwards, carried, the Council specified the following principal offices for the new corporation: chairman, vice-chairman, president and chief executive officer, vice-president, a secretary and a treasurer; only the president and vice-president need be employees.

G. Designation of Principal Officers

On motion of Doctors Smejkal-Edwards, carried, a unanimous ballot was cast for the following as the initial principal officers of the corporation:

Chairman: E. M. Dessloch, MD
Vice-chairman: Robert Krohn, MD
President and chief executive officer: Ray Koenig
Vice-president: Mahlon Bontrager
Secretary: D. N. Goldstein, MD
Treasurer: Max M. Smith, MD

H. Compensation of Principal Officers

On motion of Doctor Hamlin, seconded and carried, the Council determined that the present salaries of Messrs. Koenig and Bontrager be retained as their initial salaries in the insurance corporation.

I. Capital Required for Insurance Corporation

On motion of Doctors Smejkal-Huth, carried, the Council approved issuance to the State Medical Society of 2,000 shares of single class voting common stock (non-dividend-bearing) with a par value of $100 per share, the balance of WPS reserves going into the earned surplus account of the new corporation.

J. Certificate of Authority

On motion of Doctors Beilman-Huth, carried, the Council approved incorporation in the application for a Certificate of Authority the writing of insurance permitted by Section 201.04 (4) of the Wisconsin Statutes: "Against bodily injury or death by accident, and upon the health of persons."

K. Organizational Expenses

On motion of Doctor Williams, seconded and carried, the Council approved the recommendation that present WPS assume organizational expenses to the extent permitted by law, the balance to become the obligations of the new corporation.

L. Authorization to Execute Necessary Documents

On motion of Doctors Smejkal-Heinen, carried, the following resolution was adopted:

"Resolved, That the Council authorize the filing with the Commissioner of Insurance of Wisconsin of the various documents required for an Application of a stock insurance corporation for a Certificate of Incorporation and a Certificate of Authority; be it further

"Resolved, That the president or president-elect and the secretary be authorized to execute all documents requiring signatures of authentication on behalf of the State Medical Society which relate to the reorganization of WPS as a stock insurance corporation under Wisconsin law.

5. Status Report re WHCRI-Title XIX Contract-PSRO

Mr. Thayer reported for information that WHCRI had recently submitted a proposal to the Department of Health and Social Services for a contract to provide peer review services primarily related to length of stay on hospitalized patients under Title XIX. The proposal included provision for WHCRI subcontracting with peer review units within the state.

He reiterated that in line with actions of the Council and House of Delegates it was hoped that WHCRI would be recognized as the single statewide contracting authority for Title XIX review and for PSRO status from the federal level for Titles XVIII and XIX.

6. Nominations for State Appointments

The Council was informed that the terms of five of the seven doctors of medicine on the Medical Examining Board would expire soon; also the term of Doctor Kief on the Board of Health and Social Services.

The Council requested that all of the incumbents be nominated for reappointment by the Governor, and suggested a number of additional candidates since it is customary to provide at least three names for each position for the Governor's consideration.

7. Councilor District Legislative Day Proposal

Doctor Derus discussed his proposal that a separate week day when the Legislature is in session be scheduled for physicians from each of the councilor districts to come to the Society for briefing on the current status of bills, then go to the Capitol and meet with senators and representatives from the respective districts, take them to lunch downtown, then return to the Capitol for hearings and continued discussions. Doctor Williams reported that Milwaukee County had just decided to hold such a day in Madison. The proposal was generally accepted by the Council.

8. Proposed Master of Science in Nursing at UW-Oshkosh

Councilors had received information on this program at the March meeting. Doctor Heinen urged that the School of Nursing at Oshkosh receive an indication of support from medicine for the development of this program to help in its acceptance by the Chancellor.

On motion of Doctors Heinen-Edwards, carried, the Council voted to support the program.

9. Adjournment — 5:05 p.m.

EARL R. THAYER
Secretary

Approved by mail ballot
EUGENE J. NORDBY, MD
Chairman

SECTION OPHTHALMOLOGY

AUGUST 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EXECUTIVE SECRETARY PROPOSAL

If members of the Section on Ophthalmology have any comment on the proposal by the ad hoc committee to hire a half-time executive secretary for the Section and assess each member of the Section a mandatory $50.00, please write me. Before the executive committee of the Section takes action on this proposal we would like the opinion of the majority of Section members.—JAMES C. ALLEN, MD, Eye Clinic, University Hospitals, Madison, Wis. 53706.

WPS INSURANCE COVERAGE

Dr. Samuel S. Blankstein, Milwaukee, chairman of the insurance committee of the Section on Ophthalmology, addressed the State Medical Society's Commission on Medical Care Plans July 7 in Madison. He asked that Wisconsin Physicians Service (WPS) drop insurance coverage by optometrists for refractions. Currently WPS will pay the usual, customary, and reasonable fee for one optometric refraction per year. The Commission on Medical Care Plans, which directs the operation of WPS, rejected his request for several reasons. One reason is that when WPS sells a contract to a large union which wants vision care included, WPS is expected to provide the service, and there are not enough ophthalmologists to provide this service. Another reason Doctor Blankstein's request was denied is that WPS must remain competitive with other insurance companies. So if WPS does not provide insurance for optometric refractions, other insurance companies will and WPS is left without a sale of its insurance. WPS will, however, consult Dr. Elmer Johnson of Madison for help in rewriting the insurance brochure so the public will more fully understand the difference between optometric benefits and ophthalmological benefits.

The meeting was also attended by Dr. James C. Allen, Madison; Dr. James V. Bolger, Waukesha; and Dr. Elmer E. Johnson, Madison.

RHODE ISLAND OPTOMETRISTS WIN COURT BATTLE

A Rhode Island court has dismissed the second complaint in 16 months by the Rhode Island Ophthalmological Society for an injunction against optometrists using diagnostic drugs, a right they gained with passage of a new optometry law two years ago. Rhode Island is the only state with an optometry law that explicitly permits optometrists to use drugs.

OPTOMETRISTS AND DRUGS

The following petition was presented to the Wisconsin Optometry Examining Board June 8, 1973:

"The undersigned optometrists licensed to practice in the State of Wisconsin do hereby petition the Wisconsin Optometry Examining Board pursuant to §227.015 Wisconsin Statutes, to adopt a rule relating to the use of diagnostic pharmaceutical agents.

"Your petitioners request that such a rule be enacted because:

"1. The use of appropriate diagnostic pharmaceutical agents may reveal pathological condition that otherwise would not be disclosed.

"2. Petitioners feel an obligation to their patients to determine whether or not such pathological conditions exist.

"3. Petitioners have received training and education in pharmacology which qualifies them to employ such pharmaceutical agents.

"Roger A. Zimmerman, OD; Dennis Farrar, OD; William G. Dick, OD; R. C. Kuehl, OD; V. J. Connors, OD"

RESIDENTS COMPLETE TRAINING

Six residents completed their ophthalmology residencies at the Medical College of Wisconsin in Milwaukee in July.

Dr. David S. Hull will take a fellowship in external diseases of the eye at the Medical College of Wisconsin.

Dr. Daniel F. Marcus will stay at the Medical College of Wisconsin on a fellowship in retinal diseases.

Dr. Don C. Schmiesing will enter the U.S. Air Force and go to Scott Air Force Base at Belleville, Ill.

Dr. David F. Sweet will enter private practice in Fond du Lac.

Dr. Thomas F. Taylor will enter private practice in Oconomowoc.

Dr. Elise Torczynski will take a fellowship in eye pathology at the Armed Forces Institute of Pathology in Washington, D.C.

DATES TO REMEMBER

Oct. 6-7: Fall meeting of the Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology, Downtowner Motel, Green Bay. Info: Dr. John Ottum, Green Bay, President. □

The patient on uricosurics:
another type for Tylenol
(acetaminophen

When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism[2] and for this reason is preferred over aspirin in the gout patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%)
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for reli of pain and fever

Tylenol
(acetaminophen

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NEWS HIGHLIGHTS

New Fellows Named to American College of Physicians

Five Wisconsin physicians have been named Fellows of the American College of Physicians. They are: MDs J. Donald Coonrod, Lawrence V. Perlman, Richard A. Rudders, and Herman Tuchman,* all of Milwaukee, and James L. Basiliere of Oshkosh.

New Officers Named for Marquette-MCW Medical Alumni

John R. Litzow, MD* of Elm Grove was elected president-elect of the Marquette-MCW Medical Alumni Association by the board of directors of the organization at its annual meeting in June. The association represents almost 4,000 physician graduates of the old Marquette Medical School and its successor, the Medical College of Wisconsin. Doctor Litzow, an internist and a 1959 graduate of the school, will assume the presidency in 1974, succeeding John O. Chamberlain, MD* of Milwaukee, a 1952 graduate.

Reelected secretary-treasurer was Robert F. Purtell, Jr., MD* of Brookfield, a 1961 graduate. Members of the board of directors from Wisconsin include MDs Alfred R. Kritter,* Waukesha; Joseph C. Darin,* Milwaukee; James L. Algiers,* Hartford; Joseph S. Devitt,* Milwaukee; Thomas C. Puchner,* Elm Grove; Robert B. Leitschuh,* Racine; Thomas J. Foley,* Wauwatosa; John R. McKenzie,* Oshkosh; and Michael S. Garrity,* Prairie du Chien.

Out-of-state members of the board include MDs John Bonica, Seattle; Robert Haukohl, Coral Gables, Fla.; Steven Lewis, Galveston, Tex.; Daniel Taffe, Jr., Haverville, Mass.; Robert Schweitzer, Oakland, Calif.; and Robert Jeub, Minneapolis, Minn.

Dr. Chamberlain

Dr. Purtell

Dr. Litzow

Waukesha Medical Society Elects Officers

R. P. Froeschle, MD* of Waukesha, an anesthesiologist, was elected president-elect of the Waukesha County Medical Society at its annual meeting in June. He will take office as president in June 1974, succeeding John D. Riesch, MD,* a general surgeon of Menomonee Falls, who was installed as president this year.

Reelected secretary was Kenneth J. Dempsey, MD,* a dermatologist of Menomonee Falls. W. J. K. Clothier, MD* of Waukesha, a family physician, was reelected treasurer.

The outgoing president, Albert J. Motzel, MD* of Waukesha, was elected to a two-year term as a delegate to the State Medical Society of Wisconsin, along with Thomas P. Belson, MD,* Elm Grove.

The Waukesha Society, with 155 members, is the third largest county medical society in Wisconsin. It meets on the first Wednesday evening of each month during the year (except July and August) at different locations in the county. The Executive Committee, or Board of Directors, meets at noon on the fourth Tuesday of the month at Waukesha Memorial Hospital.

PHYSICIAN BRIEFS

Vladimir Uhri, MD

. . . Medford, recently joined the Medford Clinic. Doctor Uhri received his medical degree in Czechoslovakia, served his internship at Berwyn, Ill., and his residency at Mercy Hospital and Medical Center. Prior to joining the Medford Clinic, Doctor Uhri completed a fellowship program in gastroenterology at Sinai Hospital, Detroit.

James Gutenberger, MD

. . . Madison, recently became associated with the Dean Clinic. Doctor Gutenberger graduated from the University of Wisconsin Medical School and was in a rotating internship at King County Hospital, Seattle, Wash. Prior to joining the Clinic, he completed his pediatric and general surgery residency at the University of Wisconsin Medical School, Madison.

Frank Mohs, MD

. . . general internist, has joined the Marshfield Medical Center after fourteen years practice at the Billings, Montana, Clinic and Veterans Administration hospitals in Miles City, Montana, and Temple, Texas. After graduation from the St. Louis University Medical School, Doctor Mohs interned at affiliated area hospitals. His residencies include work at the St. Louis University Group of Hospitals, the Veterans Administration Hospital, St. Louis and University of Missouri Medical Center, Columbia. In addition, he studied at the University of Missouri as a research fellow in cardiology for the Missouri Heart Association.

Esther L. Rau, MD*

. . . Janesville, recently was featured "In Profile" in *The Janesville Gazette*. Doctor Rau, Janesville's only woman physician, started her career as a nurse and eventually went on to Loyola University School of Medicine to receive her medical degree in 1946. Doctor Rau recently was named a fellow of the American Academy of Family Physicians.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

PHYSICIAN BRIEFS . . .

John T. Sullivan, Jr., MD*

. . . associate clinical professor in the Department of Surgery, Medical College of Wisconsin, Milwaukee, has had his second medical teaching film entitled, "Surgical Insertion of Arteriovenous Shunt for Hemodialysis," accepted and approved by the American College of Surgeons Film Library. The film was presented and discussed by Doctor Sullivan at the Annual Convention of the American Medical Association, June 26, in New York City.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1973

5 Dane County Medical Society Public Health Advisory Committee
6 Committee of American Academy of Pediatrics
7 SMS Commission on Medical Care Plans
10 Trustees of SMS Realty Corporation
10 Dane County Medical Society Board of Trustees
11 SMS Grievance Committee
12 Subcommittee on Midwifery, SMS Division on Maternal and Child Welfare
13 Executive Committee, SMS Council
14 Finance Committee, Committee on Economic Medicine, Planning Committee of SMS Council
14 SMS Council
15 SMS Council
16 Dane County Medical Society Utilization Review Committee
17 Professional Nurse Exams
18 Professional Nurse Exams
20 Ad Hoc Nurse Liaison Committee
24 Executive Council, Wisconsin College Health Association
26 Subcommittee on Accreditation and SMS Commission on Scientific Medicine
27 Medical Advisory Committee, Wisconsin Emergency Medical Services Program
30 Ad Hoc Committee on Chiropractic

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

NEWS HIGHLIGHTS . . .

Outpatient Heart Clinics Resume at Oconto Falls

After several years absence the outpatient heart clinics have resumed at Community Memorial Hospital in Oconto Falls. Kenneth Strebe, MD* of Family Medical Center made arrangements for the clinics which are sponsored by the Oconto County Medical Society, Wisconsin Heart Association, and the hospital.

Agreement Reached for Heart Treatment Program, Wausau

A slowly developing heart treatment program in Wausau has reached a significant stage with the signing of an agreement for an expanded and improved cardiovascular disease program. Involved in the agreement are the Wausau Hospitals, Inc, A. Ward Ford Memorial Institute, a new heart specialist physicians' group called Mid-Wisconsin Cardiovascular Associates, and other area physicians.

The agreement includes plans for an improved heart catheterization laboratory to be installed near the coronary and intensive care units at North Hospital. Similar equipment at South Hospital will be improved and moved to North. A non-invasive laboratory also is planned. The institute and hospital have agreed to guarantee an annual professional income for physicians of Mid-Wisconsin Cardiovascular Associates. In the same agreement the Associates phsyicians have agreed to return part of their professional fees to the hospital for heart research.

Mid-Wisconsin Cardiovascular Associates is headed by M. S. Mirhoseini, MD,* a heart surgeon formerly with the Wausau Medical Center. Another heart surgeon, Charles J. Leagus, Jr., MD of Springfield, Mo., plans to join the group, and a cardiologist is being recruited.

Roy B. Larsen, MD* of Wausau Medical Center, a surgeon and a member of the Wausau Hospitals board, has been appointed medical director of the program. The position will not be fulltime.

St. Joseph's Hospital Announces Medical Staff Officers

Raymond R. Watson, MD,* thoracic surgeon, is the new president of the 300-member medical staff of St. Joseph's Hospital in Milwaukee. His three-year term began July 1. He succeeds Paul G. LaBissoniere, MD* who held that position for two consecutive terms. New vice-president is Addis C. Costello, MD;* new secretary-treasurer, Alexander J. MacGillis, MD.* Their terms also are for three years.

Doctor Watson has been a member of St. Joseph's medical staff since 1956. A graduate of the University of Wisconsin Medical School, Doctor Watson interned at Highland Park General Hospital, Detroit, Mich. This was followed by a general surgical residency at Mount Carmel Mercy Hospital and later a thoracic surgery residency at Wood, Wisconsin-Veterans Administration Hospital. He presently holds faculty rank as an associate clinical professor at the Medical College of Wisconsin.

County Society Gives Humanitarian Award

During a special recognition banquet in June, the Tri-County Medical Society (Eau Claire-Dunn-Pepin) honored Robert W. Dawson for his humanitarian and civic-minded accomplishments over the past 11 years. Since 1961 Mr. Dawson has been visiting Eau Claire Luther and Sacred Heart hospitals each Tuesday and Thursday mornings, talking with youngsters, making them smile and working "small miracles." Glenn G. Giffen, MD,* recounting Mr. Dawson's efforts, noted simply that "he makes things easier for children, the parents and us." His interest in children was highlighted several years ago when he became "Sheriff Bob" on WEAU-TV, Eau Claire. Although the show no longer is aired, the youngsters still remember him, and he remembers them. His interest in medicine and the "doctor image" began in 1961 when he was employed by the State Medical Society of Wisconsin in its health insurance program, WPS Blue Shield. It was at this time that he began his hospital visits. Mr. Dawson currently is public relations manager for Consumers Co-op Association in Eau Claire.

Alfred Jerofke, MD*
. . . dermatologist, effective July 1 relocated his practice to Milwaukee from Oak Creek where he had been practicing since early 1971. He previously had practiced in Cudahy. He still plans to reside in Oak Creek.

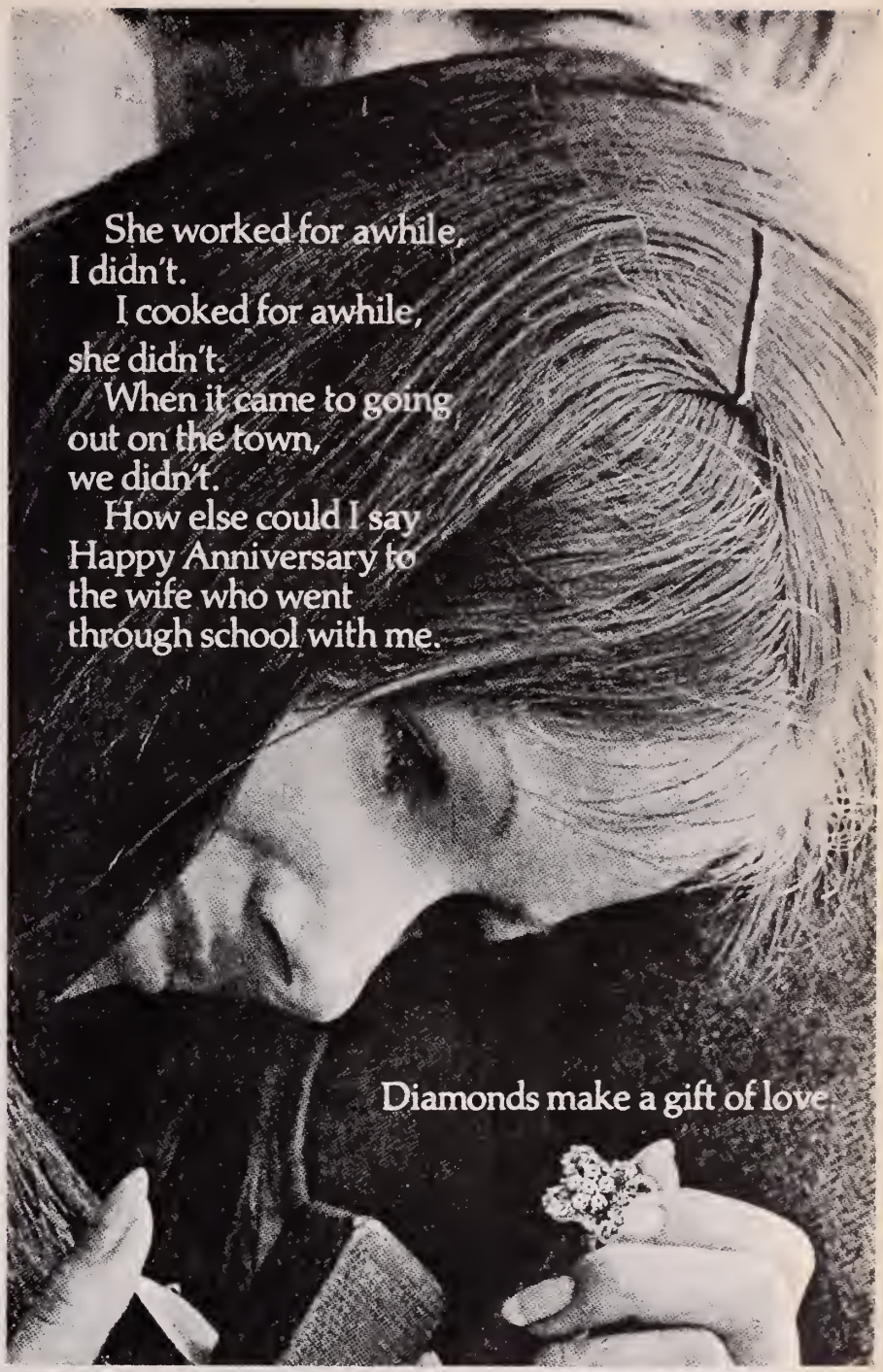
Terrance C. Coyne, MD
. . . Grantsburg, recently became associated with MDs Richard L. Hartzell* and Alan Hay as a member of the staff of the Grantsburg Clinic. Doctor Coyne graduated from the University of Wisconsin Medical School and served his internship at the United States Public Health Service Hospital in New Orleans, La. He is a member of the Wisconsin Heart Association, National Association for Interns and Residents, and the Student American Medical Association.

Russell G. Strong, MD*
. . . Manitowoc, recently was appointed Manitowoc health commissioner by the Board of Health. Doctor Strong also serves as city physician, a post he has held since 1933.

Arnold H. Barr, MD*
. . . Port Washington, recently retired from the Blue Cross of Wisconsin board of directors after 18 years of service.

John D. Hurley, MD*
. . . Milwaukee, recently was appointed medical director of the new Masonic Diagnostic and Treatment Center associated with Deaconess Hospital. He will continue to be associated with the Milwaukee County General Hospital program in cancer surgery.

Derward Lepley, Jr., MD*
W. Dudley Johnson, MD*
. . . Elm Grove and Wauwatosa, respectively, recently were given awards of distinction by the Wisconsin Heart Association. Doctor Lepley, clinical professor and chairman, Department of Thoracic-Cardiovascular Surgery, Medical College of Wisconsin, received the "Outstanding Volunteer Award" and Doctor Johnson, associate clinical professor of surgery, Department of Thoracic-Cardiovascular Surgery, Medical College of Wisconsin, received the "Outstanding Physician Award."



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PHYSICIAN BRIEFS . . .

Dr. Russell

Joseph A. Russell, MD*

. . . Random Lake, was honored recently for his 37 years of service to the Random Lake community. Doctor Russell graduated from Marquette Medical School and started his practice at Random Lake in 1936 with his uncle, the late Thomas E. Malloy, MD.

Richard C. O'Connor, MD*

. . . Wausau Medical Center, Larry P. Kammholz, MD,* Oshkosh, and Howard L. Kidd, MD,* Riverside Clinic, Menasha, recently were elected to fellowships in the American Academy of Pediatrics.

Thomas A. Starkey, MD*

. . . Wausau Medical Center, and Daniel F. Johnson, MD,* Midelfort Clinic, Eau Claire recently were installed as fellows of the American College of Obstetricians and Gynecologists.

Ivan Stanko, MD

. . . Wausau, recently has become associated with the Wausau Medical Center in the practice of neurology. Doctor Stanko graduated from Komensky University Medical School, Bratislava, Czechoslovakia. He served his residency at the University of Arizona and affiliated hospitals and prior to joining the Wausau Medical Center, he was a house physician with St. Ann's Hospital for Women, Columbus, Ohio.

NEWS HIGHLIGHTS . . .

Pharmacists and Physicians Working on Drug Formulary

In a move to help the financial plight of the elderly, Brown County pharmacists and physicians, working through their local organizations, are considering the development of a generic list of prescription drugs. Both groups support legislative action that would establish a drug quality review board and permit prescriptions to be filled with approved drug product equivalents. State law now forbids the substitution of generic drugs for brand names by the pharmacist without a physician's approval. Robert Block, MD,* representing the Brown County Medical Society, has expressed support of generic substitution of brand names. He said the proposed formulary could be developed on a voluntary basis between pharmacists and physicians.

Mandatory Rabies Vaccination Program for Wood County

The Wood County Medical Society has recommended to the Wood County Public Health Committee a mandatory countywide rabies vaccination program.

Marshfield Included in National Coronary Artery Disease Study

The Marshfield Clinic Foundation for Medical Research and Education has been selected to participate in a two-part national study of a coronary artery disease entitled "Collaborative Studies on Coronary Artery Surgery." The Foundation was selected from 54 applicants submitted to the National Heart Lung Institute, Washington, D.C., and one of 12 selected for the study.

The purpose of the study is to evaluate long and short term value of aorto-coronary vein bypass surgery in patients with coronary artery disease. Those involved in the initial phase of the study representing the Marshfield Medical Center are Richard D. Sautter, MD,* the principal investigator, William O. Myers, MD,* and Frederick J. Wenzel. The group met in Washington June 26 and 27.

Milwaukee Hospital Has Family Practice Residency Approved

Among the fifteen new family practice residencies approved by the Residency Review Committee for Family Practice May 12-13, is St. Mary's Hospital in Milwaukee. This brings the total number of training programs in the new specialty to 164. Currently there are 1,053 residents in family practice training. The American Academy of Family Physicians, American Board of Family Practice, and the American Medical Association are represented on the Residency Review Committee, which meets periodically to examine programs for approval.

Monroe Clinic Names New Administrator

The Monroe Clinic has announced the appointment of Robert H. Rieder as administrator, succeeding Harold E. Scherer who retired this spring. Mr. Rieder, who is in his 23rd year with the department of administration at the clinic, joined the clinic in 1950 following graduation from the University of Wisconsin School of Commerce with a BBA degree in administration. During his association with the clinic, Mr. Rieder has held state and national chairmanships in clinic managers associations and is a member of the Medical Group Management Association.

President Derus Addresses Wood Society

At the May 31 meeting of the Wood County Medical Society in Marshfield, Gerald J. Derus, MD* of Madison, president of the State Medical Society, discussed the following topics: Wisconsin Health Care Review, Inc.; early, periodic screening procedure for children; and the legislative bill (AB 489) which concerns the Governor's Task Force proposal for a public utility-type health services commission.

Also addressing the 32 members and 2 guests was Glenn Waldschmidt, field representative for the State Medical Society, who explained the different methods by which the State Society promotes a better contact between the individual doctors and their legislators.

NEWS HIGHLIGHTS . . .

Experimental Technique for Herniated Disks Explained

Members of the Superior and Duluth medical societies recently learned of the new experimental technique being studied for use in the treatment of herniated disks. Eugene J. Nordby, MD,* associate clinical professor of surgery at the University of Wisconsin Medical School, Madison, discussed the use of an enzyme to dissolve material in the disk causing problems, rather than mechanically removing the material through laminectomy. The enzyme used is chymopapain. It was authorized for experimental use by the FDA in 1964 and Doctor Nordby is one of 26 researchers in the United States and Canada using the material.

Formation of Wisconsin Neurosurgery Society Planned

On May 19 this year a group of neurosurgeons practicing in Wisconsin met in Madison to discuss the formation of a Wisconsin Neurosurgery Society. A Constitutional Committee was designated and firm arrangements were made at that time for further steps in the organization of the Society. The first meeting of this organization, to include both a business and scientific session, will be held in La Crosse September 15 at the La Crosse Lutheran Hospital. All interested neurosurgeons and neurosurgical residents from the State of Wisconsin as well as nearby states are welcome to attend this meeting. Further information may be obtained from Byron L. Annis, MD, 1836 South Avenue, La Crosse 54601; tel. 608/785-2400.

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PHYSICIAN BRIEFS . . .

Dr. Gundersen

A. Erik Gundersen, MD*

. . . La Crosse, thoracic and cardiovascular surgeon at the Gundersen Clinic, Ltd, recently was elected to active membership in the American Association for Thoracic Surgery. Doctor Gundersen is chief of the Department of Surgery, Gundersen Clinic and Lutheran Hospital, and is a member of the American College of Surgeons. In 1972 he was president of the La Crosse County Medical Society.

Frederick G. Hidde, MD*

. . . Sheboygan, recently joined the Kohler Company medical department on a full-time basis. Doctor Hidde, a veteran of World War II, had been in practice in Sheboygan since his discharge from service in 1945. He is a graduate of the University of Wisconsin Medical School and served his internship and residency at University Hospitals in Madison. He is a member of the medical staff of St. Nicholas and Sheboygan Memorial hospitals.

Arturo C. Sapida, MD*

. . . Walworth surgeon, in association with MDs Irwin J. Bruhn* and Daniel R. Hansen* of the Walworth Medical Group, Ltd, recently became a diplomate of the American Board of Surgery. He is on the medical staff of the Lakeland Hospital in Elkhorn.

Manucher Javid, MD*

. . . Madison, chairman of the Division of Neurosurgery, Department of Surgery, at the University of Wisconsin Medical School, recently was elected to membership in the Society of Neurological Surgeons.

Gene M. Abroms, MD*

. . . Madison, associate professor at the Center for Health Sciences, Madison, recently was promoted to full professorship. Doctor Abroms is in the Department of Psychiatry. MDs Delores A. Buchler,* Ob-Gyn, and Jane P. Wu,* Pathology, were promoted to associate professors.

Craig Anderson, MD

. . . Green Bay, recently joined the medical staff of the Webster Clinic in Green Bay. He graduated from the University of Wisconsin Medical School and took his residency at Strong Memorial Hospital, University of Rochester, New York, where he was chief resident and instructor in pediatrics. Prior to joining the Clinic, Doctor Anderson was in private practice and had been chief of the neonatal intensive care unit at St. Vincent Hospital. He is currently chief of pediatrics at the hospital.

Joseph C. Darin, MD*

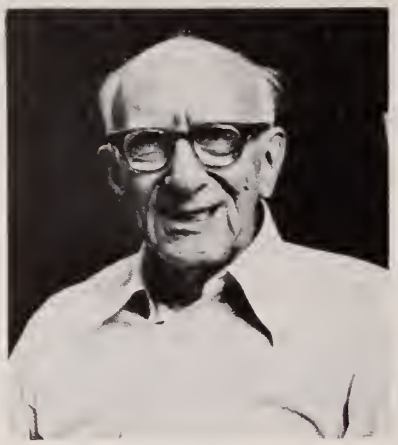
. . . director of emergency services for Milwaukee County, has been coordinating plans for a pilot project that would establish a paramedic team to provide emergency rescue services from a specially equipped county ambulance. The proposal has been submitted to the Milwaukee County Welfare Board. Similar programs are successfully operating in such cities as Seattle and Los Angeles.

David Bjarnason, MD*

. . . a rheumatologist, has joined the Marshfield Clinic in Marshfield. He graduated from the University of British Columbia Medical School. A native of Manitoba, he interned at the Ottawa Civic Hospital and served a rotating residency at Rochester's Mayo Clinic. Before coming to Marshfield, Doctor Bjarnason practiced and taught under a two-year rheumatology fellowship at the University of Southern California, Los Angeles.

Armand J. Quick, MD*

. . . research professor, Hemostasis Research Laboratory, Medical College of Wisconsin, Milwaukee, recently was awarded an honorary doctor of science degree by Marquette University.



Dr. Bachus

Arthur Bachus, MD*

. . . Ripon physician for 30 years, recently retired from practice. A native of Ft. Atkinson, he practiced in an Upper Michigan turberculosis center for 6½ years before coming to Ripon in May 1943. Doctor Bachus taught school and served in the United States Army during World War I. Doctor Bachus entered medicine relatively late in life, graduating from Marquette University School of Medicine in 1932. (Photo courtesy of RIPON COMMONWEALTH PRESS)

Harold M. Swartz, MD*

. . . associate professor in the Department of Radiation Therapy, Medical College of Wisconsin, Milwaukee, has been awarded two research grants totaling $5,800 by the American Cancer Society, according to an announcement in July by Dennis W. Laudon, president of the ACS's Milwaukee Division. The research funds were approved by the Cancer Society's medical and scientific committee and made possible through the community's continued support of the annual Cancer Crusade.

Drake Austin, MD*
Herbert Sandmire, MD*

. . . Green Bay obstetricians-gynecologists, have moved their offices to the Physicians Condominium Building, located north of Bellin Memorial Hospital in Green Bay. The physicians had been associated with the Beaumont Clinic in Green Bay.

William Forkner, MD*

. . . Sheboygan, recently opened a private general practice in association with MDs F. P. Nause,* C. A. Graf,* R. W. Pointer,* and M. G. Jumes.* Doctor Forkner graduated from the University of Texas Medical School and had been the industrial physician for the Kohler Co. before entering private practice.

James R. Manier, MD

. . . returned to the Marshfield Medical Center staff after spending two years teaching and practicing in Minnesota and Iowa. He is a medical school graduate of Tennessee University, Nashville. After interning at University Hospitals in Madison, he completed residency work at the University of Pennsylvania and Baltimore City Hospital. Doctor Manier's subspecialty is gastroenterology.

George E. Magnin, MD*

. . . Marshfield, has been elected to the board of directors of Environment Wisconsin, a non-profit organization that works to coordinate the efforts of environmental groups throughout the state. He will serve a two-year term on the board.

J. Greg Hoffmann, MD*

. . . Hartford physician for 68 years, recently was honored for his services to the community and will be honored in the future because "he is continuing to serve the medical needs of the people." Doctor Hoffmann, who is 92, is semi-retired but still makes hospital rounds and sees a few patients. Besides practicing, Doctor Hoffmann is Hartford's public health officer, a position he has held for over 60 years. He graduated from the Wisconsin College of Physicians and Surgeons in 1904 and has practiced in Hartford since 1905.

J. B. Cabaltica, MD*

. . . Baraboo, recently joined the practice of Leandro M. Queniahan, MD.* A graduate of the University of Santo Tomas, Manila, The Philippines, he served his internship and surgical residency at St. Joseph's Hospital, Chicago. Prior to coming to Baraboo, Doctor Cabaltica was located in Mauston.

Cancer Data Center at UW Encompasses Statewide Efforts

New methods of treatment for leukemia and lymphoma are currently being developed in Wisconsin. The Wisconsin Hematology Study Group is combining the efforts of 27 state physicians to provide improved care for the victims of these cancers.

According to Donald R. Korst, MD,* professor of medicine at UW-Madison, new treatment programs have proved "at least as effective as older forms of treatment, while offering advantages in a number of cases."

A data center, established in 1969 at the University of Wisconsin-Madison, is compiling the research of participating physicians in Madison, Milwaukee, Marshfield, La Crosse, Green Bay, Racine, and the Wood VA Hospital near Milwaukee. Information about their leukemia and lymphoma cases and the results of treatment is sent to the group's shared computer and statistical facilities in Madison.

According to Doctor Korst the center has provided improved communication between physicians and placed more patients into the study to answer important questions about treatment. "This has resulted in better care for patients because it involves family physicians as well as experts at the UW Medical Center," he said. "It has also established the University of Wisconsin as the data gathering base."

Results of this effort involve not only new treatment, but plans for future research as well. In cases of acute leukemia Doctor Korst states that "we are going on to ask if we can induce more and longer remissions through the use of drug treatments tailor-made to the patient."

A program is also being planned to treat Hodgkin's and lymph node tumors with the combined use of drug and x-ray therapy.

Research funds, contributed in the past year by the Wisconsin Division of the American Cancer Society, are used strictly to keep the center going, Doctor Korst pointed out. Participating physicians contribute their own time and expertise and pay their own postage and travel expenses. "This allows us to do clinical research at a fraction of the usual cost," he said.

"The current treatment protocols being summarized for reporting in the medical literature include data from over 300 patients at a total cost of less than $40,000. This is a marked contrast to national studies involving fewer patients but costing several hundred thousand dollars," says Doctor Korst.

"We are all convinced that the important questions of the future in the treatment of serious illnesses will be answered by the combined efforts of the state's medical community," said Doctor Korst. □

George Thomas, MD*
Paul Odland, MD*
Nicholas Papadakes, MD*
Gerald Gredler, MD

. . . orthopedic surgeons in the Janesville area, have opened a new medical and surgical facility near the Mercy Hospital in Janesville. The new two-story brick clinic has been named Janesville Orthopaedic Surgery Group. The orthopedic surgery clinic, founded in 1950 by Doctor Thomas, has been closed.

Richard Calvin, MD

. . . Frederic, recently became associated with MDs, William A. Fischer* and Donald F. Schwab* at the Frederic Clinic. A graduate of the University of Illinois Medical School, Doctor Calvin interned at San Bernardino County Hospital in California and served in the United States Army for two years. Since his discharge from service, he had been a member of the emergency medical staff at Sacred Heart Hospital, Eau Claire.

Ruben Aguas, MD

. . . has joined the Department of Otolaryngology at the Marshfield Clinic in Marshfield. He is a graduate of the College of Medicine at the University of the Philippines, Manila. After a rotating internship at the Philippine General Hospital Medical Center, he completed residency work there and at New York's Bellevue Medical Center. Doctor Aguas also has served as a resident in General Surgery at Columbus Hospital, New York, and as a resident in otolaryngology at Metropolitan Hospital Center, New York. □

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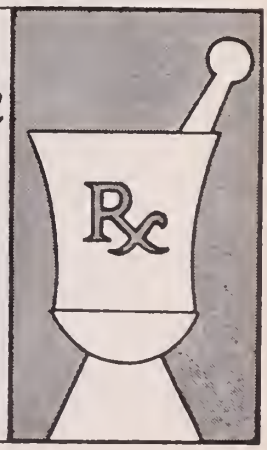

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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OBITUARIES

William C. Henske, MD, 76, Chippewa Falls, died Mar. 25, 1973 in Chippewa Falls.

Born July 12, 1896 in St. Louis, Mo., Doctor Henske graduated from St. Louis University School of Medicine in 1920 and served his internship at Chicago Lying-In Hospital and City Hospital in St. Louis, Mo.

Doctor Henske, a family physician and surgeon, had practiced in Chippewa Falls since 1921 except for service in the United States Army Medical Corps from 1941-46. He was formerly president of the Wisconsin State Board of Medical Examiners, served as city health officer in Chippewa Falls, and also served as chairman of the State Medical Society's Committee on Hospital Relations. Doctor Henske became a member of the "50 Year Club" of the State Medical Society in 1970. He also was a member of the American Academy of Family Physicians.

He also was a member of the Chippewa County Medical Society and American Medical Association.

Surviving are his widow and one daughter.

John J. LaBreche, MD, 67, Stanley, co-founder of the LaSalle Medical Service, died Apr. 18, 1973 in Stanley.

Born on May 25, 1905 in Ishpeming, Mich., Doctor LaBreche graduated from Marquette University School of Medicine in 1932 and served his internship at St. Joseph's Hospital in Marshfield. He served in World War II with the United States Army Medical Corps and was discharged in 1945. On April 1, 1962, Doctor LaBreche and Dr. Douglas A. Sallis formed the LaSalle Medical Service of Stanley.

He was a member of the Chippewa County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow LaParta; a son, Dr. Michael LaBreche, Madison; a daughter, Mrs. Dennis Murphy, Plainfield, Vt.; a stepson, Howard LeDuc, and a stepdaughter, Mrs. John Gospodar, both of Stanley.

Russell Ray Crigler, MD, 73, South Milwaukee, died May 5, 1973 in Milwaukee.

Born on Jan. 8, 1900 in Welch, Cherokee Nation, Indian Territory, Doctor Crigler graduated from Marquette University School of Medicine in 1928 and served his internship at Marquette University Hospital. He served in the United States Army during World War I.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Jennie.

Raymond A. Toepfer, MD, 72, of Brookfield, retired West Allis physician, died May 16, 1973 in West Allis.

Born on Aug. 1, 1900 in Madison, Doctor Toepfer attended the University of Wisconsin until 1922 and completed his medical course at the University of Illinois Medical School in 1925. He served his internship at Milwaukee Hospital, now Lutheran Hospital of Milwaukee. He had practiced in the Milwaukee area for 40 years until his retirement in 1966. He had been a staff member of St. Luke's Hospital, Lutheran Hospital of Milwaukee, and West Allis Memorial Hospital. He served on the steering committee of the latter. Doctor Toepfer served in the United States Army during World War I.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and American Academy of Family Physicians. He was a great sportsman; and as a dog lover, served as president of West Allis Training Kennel Club.

Surviving are his widow, Carla; four daughters, Mrs. John (Joan) Linnan, Brookfield; Mrs. James (Phyllis) Brothwell, Mesa, Ariz.; Mrs. Robert (Lorraine) Craig, Madison; and Mrs. James (Suzanne) Bethards, Des Plaines, Ill.

Julius M. Meyer, MD, 56, Milwaukee, chief of staff at St. Francis Hospital, died May 27, 1973 in Milwaukee.

Born on June 17, 1916 in New Orleans, La., Doctor Meyer graduated from Marquette University School of Medicine in 1943 and served his internship at Charity Hospital, New Orleans, La. His residency was taken at the Veterans Administration Hospital, Wood, Wis. Doctor Meyer served in the United States Army Medical Corps during World War II. He was past chief of staff at West Allis Memorial Hospital and a former president of the Wisconsin Chapter of the Arthritis Foundation.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mary Louise; three daughters, Mrs. Jeremy (Margaret) Meek, Butte des morts, Wis.; Mary and Kathleen, Milwaukee; and four sons, Michael, St. Louis, Mo.; and John, Francis, and Peter, of Milwaukee.

Lars F. Gulbrandsen, MD, 68, Viroqua, died May 30, 1973 in Viroqua.

Born on Apr. 13, 1905 in Westby, Wis., Doctor Gulbrandsen graduated from the University of Illinois College of Medicine in 1931 and served his internship at Illinois Research Hospital. In 1935, he received the Distinguished Noguchi Award for bacteriology research. Doctor Gulbrandsen contributed to the construction of the Vernon Memorial Hospital in Viroqua, of which he was a member of the staff and hospital board. During World War II, he received the Selective Service Commendation for wartime service.

He was a member of the Vernon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two daughters; Mrs. Charles Starr, Portland, Ore.; and Mrs. David Opheim, Ft. Dodge, Ia.; and a son, Carl, Madison.

Claiborne Williams, MD, 64, Milwaukee, died June 13, 1973 in Milwaukee.

Born on Jan. 31, 1909 in Gadsden, Ala., Doctor Williams graduated from Vanderbilt University Medical School, Nashville, Tenn., in 1936 and served his intern-

ship and residency at Vanderbilt University Hospital. Doctor Williams served in the United States Army during World War II.

Surviving are his widow, Evelyn, and two children.

Joseph F. Rose, MD, 89, Lena, died June 7, 1973 in Oconto.

Born on June 16, 1883 in Green Bay, Wis., Doctor Rose graduated from the University of Illinois, Chicago, in 1906 and served his internship at West Side Hospital in Chicago. Doctor Rose was the first president of the village of Lena when it was incorporated in 1921 and had been a physician there since 1907.

He was a member of the Oconto County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

There are no immediate survivors. □

EDITORIAL

A GOOD FRIEND

The Viroqua area said a sad farewell Sunday to Dr. Lars Gulbrandsen. He was one of the area's most active people, vitally interested in the health and welfare of the public, and he lived this belief throughout his professional life.

But he was beyond a professional man. He got things done. It happened in the school system where he enjoyed being a board member. It happened in his church which he helped in many ways over the years. He got things done at the hospital, from start to additions. And his interest did not stop at those well-known activities.

Perhaps his greatest asset was the big smile, friendly greeting, and cheerful attitude whenever one spoke to him, even for a few, brief words. He managed to convey a sincerity and confidence few people can match, yet be jovial about most any situation. Despite the problems he shared with patients, friends and carried himself, Dr. Lars was a good friend to all. And that's the ultimate which can be said about anyone. — VIROQUA BROADCASTER & CENSOR, June 7, 1973

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and Director, Section of Endocrinology and Metabolism
University Hospital, Boston, Massachusetts

SHELDON G. SHEPS, M.D.
Director of Hypertension Clinic, Mayo Clinic
and Associate Professor of Medicine, Mayo Medical Clinic
Rochester, Minnesota

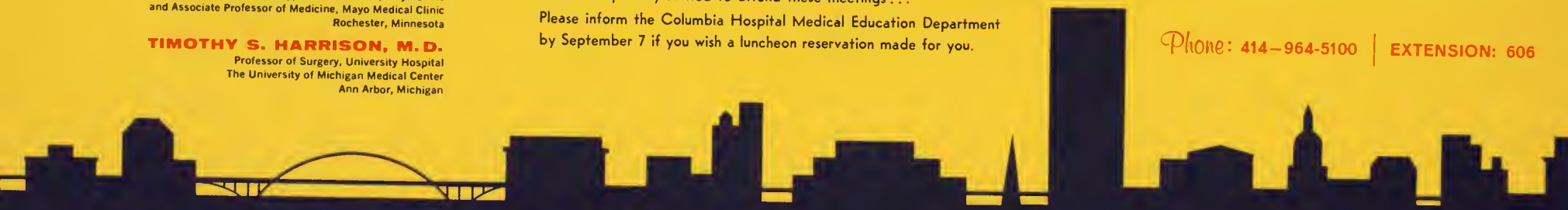
TIMOTHY S. HARRISON, M.D.
Professor of Surgery, University Hospital
The University of Michigan Medical Center
Ann Arbor, Michigan

HYPERTENSION, DEFINITION, EPIDEMIOLOGY • LOW RENIN HYPERTENSION
X-RAY DIAGNOSIS OF HYPERTENSION • RENOVASCULAR HYPERTENSION
SURGERY FOR RENOVASCULAR HYPERTENSION • ADRENAL SURGERY OF HYPERTENSION
HYPERTENSION AND PREGNANCY • TESTS AVAILABLE TO PRACTICING PHYSICIANS
OFFICE APPROACH TO DIAGNOSIS • DRUG THERAPY

OPEN TO ALL PHYSICIANS, RESIDENTS, MEDICAL STUDENTS, INTERNS

You are especially invited to attend these meetings . . .
Please inform the Columbia Hospital Medical Education Department
by September 7 if you wish a luncheon reservation made for you.

Phone: 414—964-5100 | EXTENSION: 606



COLUMBIA HOSPITAL SEPTEMBER 11 / 9:00 AM 5:00 PM

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, and MISCELLANEOUS. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. BOXED AD RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the first of the month preceding month of issue; e.g., copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING: MULTIspecialty clinic in northwestern Wisconsin is expanding; group seeking

1. Internist
2. General Surgeon
3. Allergist

Ultramodern 500-bed hospital located close to clinic. Excellent recreational area. Salary first year, corporate member thereafter. Young group, incorporated, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 396 in care of the Journal. 6tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

INTERNIST NEEDED: BOARD certified or eligible. Join internist, radiologist, general surgeon, and EENT physician (all certified with another internist joining soon). Modern clinic building in university city. Population 100,000 with 3 fully equipped hospitals. Partnership opportunity after 3 years. J. B. Grace, MD, Green Bay Clinic, Ltd., 123 N. Military Ave., Green Bay, Wis. 54303. 6–8/73

WANTED: YOUNG BOARD CERtified or board eligible Obstetrician and Gynecologist to join three-man group which is part of a multi-specialty partnership (40 physicians) in a rural Midwest community serving an area of approximately 250,000. Contact Dept. 394 in care of the Journal. 5–10/73

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTItioner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $30,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

EXCELLENT OPPORTUNITY: General practitioner needed in established practice. Modern clinic adjacent to 85-bed hospital. Progressive community of 6800, excellent schools and recreational facilities. Starting salary $32,000, partnership after first year. Phone, visit or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372–4177. p4-9/73

THE WAUSAU MEDICAL CENter (formerly Wausau Clinic), a family medicine–multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. Psychiatry
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospital insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842–0411. 6–8/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

JANESVILLE RIVERVIEW CLINIC, Ltd. (formerly the Pember–Nuzum Clinic), 17-man multi-specialty group, seeking specialists in Internal Medicine, Pediatrics, and Ophthalmology. Excellent retirement and insurance plans. Write or call collect: P. Richard Sholl, MD, Box 551, Janesville, Wis. 53545; tel: 1–608/752–7811. 4tfn

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Dermatology
3. General Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 7-12/73

KROHN CLINIC, LTD., NEEDS physician in rural family practice. Group practice circumstances excellent but must be in early 30s or less. Please contact William B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams Street, Black River Falls, Wis. or phone collect 715/284-4311. 7tfn/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY or GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months. Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

IMMEDIATE OPENINGS FOR physicians in OB-GYN specialty to establish a successful practice in a multispecialty clinic located close to hospitals. In-clinic medical student teaching opportunity. University and college city. Year around indoor and outdoor family activities of all types. Salary plus excellent benefits first year and corporate member thereafter. Interview expenses paid. Call collect to D. W. Shea, MD, Beaumont Clinic, Ltd., 1821 S. Webster Ave., Green Bay, Wis. 54301. p5–9/73

SHELL LAKE CLINIC, LTD., Shell Lake, Wis., expanding to 7-man group. Three family physicians and one surgeon desire additional two family physicians and one internist. New 70-bed general hospital adjoins clinic. Excellent remuneration in corporate practice. City surrounds one of largest and finest swimming and fishing lakes in Northwest Wisconsin. Call 715/468–2711 or write to Darrell Bailey, Clinic Mgr., 209 4th Ave., West, Shell Lake, Wis. 54871. 3–8/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel: 608/339–3326. 6tfn

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis.; Tel.: 414/637–9271. 4tfn

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

IMMEDIATE OPENING FOR Internist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB–GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn

WANTED: PHYSICIANS, SPECIALists or Generalists, who want to practice medicine in a semi-rural area but sti have the advantages of the state's large cultural, population, and medical cente within twenty-five minutes travel.

Discover Ozaukee County. A beautifu blend of a rural agricultural setting i terspersed with growing communitie which are progressive but still preser the charm and beauty of early Wisco sin history.

Physicians are urgently needed to pr vide the key that will open the healt care door for the 55,000 people wh call this county their home. These pe ple are more affluent than the averag in Wisconsin. They need and want ph sicians to enjoy living and working i this area with all its advantages.

This is a prime recreation area on th shores of Lake Michigan, just north the hustle and bustle of Milwaukee.

St. Alphonsus Hospital in Port Wasl ington is an orderly, modern facilit ready to provide acute, general hospit care in the heart of this county con munity. It is ideally located in the cent of Ozaukee County about 20 miles fro other hospitals to the north, south, an west. A new, 12-man office building co nected to the hospital will be ready b August 1, 1973, and other office spa is available in most of the nearby citi and villages.

If you are interested in the good lif and a good practice, contact Georg Seidenstricker at St. Alphonsus Hospita 743 N. Montgomery Street, Port Wasl ington, Wis. 53074. Tel: 414/284–551 6–10/7

THE MONROE CLINIC IS INTE viewing Surgical Specialists to join t present 38 MD staff. Excellent offi facilities and a most modern 360-be hospital. Top offers in salary and fring benefits. Monroe is a unique communi with tremendous family living conditio with large city opportunities. We ha openings in the following Surgical Sp cialties:

1. Urology
2. Rectal and Colon Surgery
3. Orthopedic Surgery
4. Otolaryngology

Please contact Robert E. Hassler, MI Procurement Chairman, The Monro Clinic, Monroe, Wis. Tel: 608/325–712 8t

THE MONROE CLINIC IS INTE viewing Medical Specialists to join the present 38 MD staff. Excellent offi facilities and a most modern 360-be hospital. Top offers in salary and fring benefits. Monroe is a unique communi with tremendous family living conditio with large city opportunities. We ha openings in the following Medical Sp cialties:

1. Family Practice
2. Dermatology
3. Hematology
4. Allergy
5. Proctology

Please contact Robert E. Hassler, MI Procurement Chairman, The Monro Clinic, Monroe, Wis. Tel: 608/325–712 8t

ASSISTANT MEDICAL DIRECTO IDS Life, a subsidiary of Investors D versified Services, is seeking an inter ist or general practitioner. This is a

DIRECTOR
of
MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employe fringe benefit program and salary. Send vita to:

EDWIN A. MUNDY,
DIRECTOR
Institutions & Departments
8731 Watertown Plank Rd.
Milwaukee, Wis. 53226

lministrative position on the Minnc-
olis home office staff of a rapidly
owing life and disability income in-
rance company. Primary responsibil-
y is for the medical evaluation of in-
rance applications. Ability to interpret
ectrocardiograms is required. Position
fers advancement potential, excellent
nefits, profit sharing, and expenses for
location to Minneapolis. Send resumé
confidence to Dan Willius, 3300 IDS
ower, Minneapolis, Minn. 55402. 8-9/73

GENERAL PRACTICE AVAIL-
ble, lucrative—sudden death; large
ctive practice in community of 35,000
ith 50,000 population in area. Well
uipped 8-room office; good for one
two MDs. Contact Attorney A. A.
uchin, 1004 Washington St., Manito-
oc, Wis. 54220; tel. 414/682-7713.
8-10/73

PUT IT ALL TOGETHER: THE
tisfaction of rural general practice plus
e joys of small town life. Join us in
e fun at the Markesan Medical Center.
all 1-414/398-2321, Markesan, Wis-
nsin. p8-9/73

PEDIATRICIAN WANTED TO JOIN
pediatricians in suburban Milwaukee
ea. Liberal salary first year. Apply:
R. Guy, MD, Waukesha Pediatric
ssoc., 1111 Delafield St., Waukesha,
is. 53186. 8-12/73

LAKE SUPERIOR CALLING WELL
ained family practitioners, internists,
diatricians, otolaryngologist or urolog-
t eager to practice where skills will be
lly used and appreciated by the people
ving in Ashland and surrounding draw-
g area, 120,000 in all. Brand new 101-
d hospital with 5-bed ICU/CCU and
tremely well equipped lab headed by
ll-time radiologists and complete range
x-ray facilities. Continuing education
ograms for medical, nursing and ancil-
ry staffs. Other physicians practicing
Ashland: 3 ophthalmologists, 1 Ob-
yn specialist, 1 psychiatrist, 1 internist,
new, busy general surgeon, and 7 gen-
al practitioners. Progressive school sys-
m, new high school, vocational school
d 4-year college. Need guarantee? A
ncrous one is available. To arrange
pense paid visit, write, sending CV to
red Tidstrom, MD, 600 14th W., Ash-
nd, Wis. 54806, or call collect after
00 pm, Ken Morrow, MD, 715/682-
321. 8-10/73

WANTED: GENERAL PRACTI-
oner in city of Markesan, Green Lake
ounty, Wis., to join two AAFP mem-
ers, so that we can all enjoy more nor-
al time for relaxation and family life.
alary first year, partnership thereafter.
ontact D. P. Cupery, MD, Markesan
Medical Center, P. O. Box 247, Marke-
n, Wis. 53946. 8tfm/73

LOCUM TENENS NEEDED LAST 3
eeks in September and first week in
ctober for well organized solo practice
Red Granite, Wisconsin. Brand new
ffice building with hospital facilities in
vo hospitals. Working hours agreeable
nd per agreement. Compensation very
dequate. Plenty opportunity for recrea-
on, sports, and outdoors. Please come
nd see us or call Steve R. Osicka, MD,
Burman Building, Red Granite, Wis.
54970. Tel. 414/566-2323; residence.
414/361-0512. 8/73

PRACTICES AVAILABLE

GP NEEDED TO REPLACE DE-
ceased MD in established practice. En-
tire inventory for sale, excellent hospital
facilities, good school in resort and rec-
reational area. SE Wisconsin. Contact
Box 457, Williams Bay, Wis. 53191.
g6tfn/73

RETIRING PHYSICIAN WANTS
to rent his office space. Active practice
and equipment included in rent. South-
eastern Wisconsin city with 48,000
population. June availability possible.
Tel: 414/542-9114. 4tfn/73

EXCELLENT PRACTICE OPPOR-
tunity for general surgeon and pediatri-
cian within a non-clinic structure. For
further information kindly write: John
J. Van Driest, MD, President, Sheboygan
Medical Arts Bldg., Inc., 1226 North
8th St., Sheboygan, Wis. 53081. 8-9/73

PRACTICE FOR SALE: 30 MILES
northwest of Milwaukee. Small town
with access to new $4 million hospital
and Milwaukee specialists. Retirement
plans create this fine opportunity in a
growing community. Combined residence
and office plus adjoining lot for expan-
sion. Call 414/629-5511. 8-10/73

LARGE PRACTICE AVAILABLE:
Before you make any decison please see
this practice. Good for two GPs. Do
surgery, GP, OB-GYN. Well built and
furnished practice. All recreation avail-
able right here with hospital in town.
Contact Dept. 392 in care of the Journal.
8-10/73

MEDICAL OFFICE AND HOME
combination for sale by physician retir-
ing. Five-room office and three-bedroom
colonial home with studio apartment or
fourth bedroom, sundeck. Suitable for
general, specialty, or industrial practice.
Charles Faber, MD, 2233 West Capitol
Drive, Milwaukee 53206; tel. 414/871-
5020. 8/73

MEDICAL FACILITIES

WANTED: PHYSICIAN FOR
small farming community 20 miles from
Chippewa Falls. Hospital 5 miles. Serv-
ing 3500 pop. Office space available in
new medical building. Contact Mr. Jno.
W. Meyer, State Bank of Boyd, Boyd,
Wis. 11tfn

EXCELLENT OPPORTUNITY FOR
pediatricians and internists to establish
practice in beautiful new physicians
condominium building adjacent to Bellin
and St. Vincent hospitals in Green Bay,
Wis. Patients immediately available on
referral from other physicians in the
building. Call or write H.F. Sandmire,
MD, OB-GYN Associates of Green Bay,
Ltd., 704 S. Webster Ave., Green Bay,
Wis. 54301. 7tfn/73

TWO MORE DOCTORS NEEDED
in Ripon. Modern four-year-old medical
clinic building available for rent or sale,
specifically built for two or three doc-
tors. Contact: Mrs. O. A. Dittmer, 612
Woodside Ave., Ripon, Wis. 54971; tel.
414/748-3636. g4tfn/73

THE NEED CONTINUES! ! EVEN
though a number of excellent physicians
has come to practice in our community,
we need more doctors . . . particularly
family practitioners, internists, ortho-
pedists, otolaryngologists, and ophthal-
mologists. Join others in discovering
Watertown, Wisconsin. New Health Care
Center includes 100-bed general hospital,
connecting (but separate) medical office
building, and connecting 120-bed nursing
home.

Progressive and growing community.
Good location between Milwaukee and
Madison. Medical practice area includes
40,000 people. Good schools. Beautiful
parks, trees and lakes. Stable economy.

Medical staff supporting recruitment
efforts. Write or call: Leo B. Bargielski,
Executive Director, Watertown Memorial
Hospital, Watertown, Wisconsin 53094;
tel. 414/261-4210. 7-9/73

FOR SALE: THE LATE DOCTOR
Parish's office and waiting room equip-
ment including examining table, equip-
ment for eye testing, two typewriters,
medical instruments, etc. Contact Mrs.
G. A. Parish, 511 Janssen Ave., May-
ville, Wis. 53050. g12tfn

MISCELLANEOUS

GUIDELINES FOR BLOOD-ALCO-
hol testing by physicians, available
from the CES Foundation, State Medi-
cal Society of Wisconsin, Box 1109,
Madison, Wis. 53701. Includes request/
consent form for drawing blood. Cost:
25¢ per form to be sent with order.

WANTED: ADVERTISEMENTS
for this section. Open to physicians, in-
dividuals, firms, organizations who have
something they would like to sell, or are
looking for something to buy, or have a
service available, which might be of in-
terest to physicians.

PUBLICATIONS

*Guide for School Health Examina-
tions.* 40-page, 1970 revised edition,
prepared and published by the State
Medical Society's Division on School
Health in cooperation with the Wiscon-
sin State School Health Council, avail-
able from the CES Foundation, State
Medical Society of Wisconsin, Box 1109,
Madison, Wis. 53701, at cost of $1.00
per copy to be sent with order.

Wisconsin Week-End. A charming lit-
tle publication filled with original and
informed writing about fascinating by-
ways, historic sites, events, sports, recre-
ational and cultural activities, museums,
shops, art fairs and out-of-the-way places
throughout the State. Unrivaled prescrip-
tion for ennui, valuable aid to the short-
trip motorist, delightful addition to your
personal library or waiting room. Pub-
lished 26 times yearly. Winner State
Historical Society Award of Merit. Only
$4 a year in Wisconsin. Wisconsin Week-
End, Spring Green, Wis. 53588. 6/73

What Can We Do About Limited Vision? The right of persons with limited vision not to be blind is the subject of this Public Affairs Pamphlet No. 491, written by Irving R. Dickman. The author outlines some of the major measures in the areas of prevention, detection, and rehabilitation that can assure all persons with visual disabilities the opportunity to make the most out of the vision they do have. Available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, NY 10016.

Securing the Legal Rights of Retarded Persons. This Public Affairs Pamphlet No. 492 surveys the progress made in awakening the public to the potential of many retarded persons and the battles yet to be won in assuring them their full legal and civil rights. Written by Elizabeth Ogg, it is available for 35 cents from the Public Affairs Committee, 381 Park Avenue South, New York, NY 10016.

HMO Sourcebook. Publication of this special edition of a continuing study of state laws affecting the prepayment of medical care, group practice, and HMOs has been announced by the Health Law Center, Aspen Systems Corporation.

The study is the reference source on HMOs for the U.S. Department of Health, Education, and Welfare and the 400-page special edition of this study, the *HMO Sourcebook,* has been prepared for health professionals, with HEW permission.

The *HMO Sourcebook* is being offered for $24.75. The reference work is invaluable for health professionals interested in forming or operating a group practice or HMO, affiliating with or using such an organization, or gauging the possible threat to present fee-for-service organizations.

Those statutes, rulings, attorney general opinions, case laws, and legislative intentions, which make up the general legal climate in each state and which tend to block or facilitate the establishment of pre-paid medical care, are reviewed in the Sourcebook in clear and concise language.

The obstacles or drawbacks to the formation of HMOs, the publisher points out, depend on the legal climate in each state, and the *HMO Sourcebook* enables the health professional and his attorney to better evaluate present and future prospects in each state for HMOs and prepaid group practice organizations.

According to the publisher, the *HMO Sourcebook* will be of special interest to health insurers, hospital administrators and other hospital management personnel, group insurers, regional medical plans and councils, state medical associations, state legislators, physicians in group practice, corporate nursing homes, union, fraternal, and benevolent organizations, personnel directors and medical directors of large corporations, as well as their attorneys and accountants. While the book avoids legal jargon, statute and case law references are presented for further study and the Sourcebook includes an alphabetical listing of cases, state listings of cases, and a listing of federal legislation.

The *HMO Sourcebook* was prepared under the supervision of Gerald Seifert, Director, the Health Law Center, and edited by Janet M. Benyak, J. D. The Sourcebook contains a foreward by Clark C. Havighurst, Professor of Law, Duke University, and Director of the Committee on Legal Issues in Health Care.

Copies of the *HMO Sourcebook* may be obtained for $24.75 by writing to Dept. RR, The Health Law Center, Aspen Systems Corporation, 11600 Nebel Street, Rockville, Md. 20852.

Illustrated Programmed Gross Anatomy is the latest textbook by Verlee E. Gross. Already established as a well-known and respected author in the field of paramedical books Miss Gross offers in her newest book the answer to the problem of teaching basic anatomy. Over 1200 illustrations, some in color, make possible a revolutionary and simplified programmed method to introduce students to the various components of human anatomy. Included in the 416-page, 8½ x 11" text is an 88-page removable study section. All material has been reviewed and edited by ten doctors in the various medical specialties.

This unusual new book can be considered a "primer" for basic anatomy. From it students can progress to the more involved anatomical texts which they will then find easier to understand. It is also a valuable research text for fast location of a specific organ or body component.

Developed as a pictorial method of learning anatomy the text parallels the material in the author's "Mastering Medical Terminology" (1969). The latter book contains the descriptive material of each anatomical system as well as diseases and surgical procedures for each. It also contains a study section.

Both books, as well as Miss Gross' first, widely used text, "The Structure of Medical Terms" (1968)—a working textbook, have pronunciation of ALL medical terms and English translation of the components which make up these terms.

The simplified study method of all three texts is designed to eliminate the mystery which accompanies medical terminology and which creates most of the difficulties. The three books make classroom teaching much easier and are also adaptable for self-study.

Illustrated Programmed Gross Anatomy sells for $10.00, "Mastering Medical Terminology" is also $10.00 and "The Structure of Medical Terms" retails for $7.50. To obtain explanatory literature on each of the texts and teaching aids available for each book write Halls of Ivy Press, 13050 Raymer Street, North Hollywood, CA 91605.

Emergency Health Services Digest No. 4. Prepared by the Division of Emergency Health Services of the Health Services and Mental Health Administration —DHEW, the *Digest* has in-depth summaries of selected recent articles from professional journals and other periodicals. The material will help those engaged in the planning, programming and delivery of emergency medical services to keep abreast of current literature pertinent to their problems. The longer summaries in this issue will make the section on clinical emergency care especially useful to medical-paramedical people who deal with patients in ambulances and hospital emergency departments.

Copies of *Emergency Health Services Digest No. 4,* DHEW Publication No. (HSM) 73-2039, are available from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. Price 70 cents each by mail; over-the-counter at Government bookstores 45 cents.

ANNOUNCEMENTS

THE UNITED STATES SKI ASSOCIATION, Denver, is soliciting entries for its 1974 Ski Medicine Research Competition.

Competition is conducted by the Association with the Committee on Sport Medicine of the American Academy of Orthopaedic Surgeons acting in an advisory capacity. It is aimed at stimulating studies leading to reduced ski injuries according to Dr. Arthur E. Ellison, Williamstown, Mass., member of the Academy Committee assisting the ski association.

Those eligible to compete are accredited physicians. research workers, engineers, and medical students who are citizens of the United States or its possessions. Entries are sought in the statistical, epidemiological, clinical, and mechanical aspects of ski injuries. Deadline for entries is Dec. 15, 1973.

For complete details contact James G. Garrick, MD, National Repository for Ski Medicine, Division of Sports Medicine, Department of Orthopaedic Surgery, University of Washington School of Medicine, Seattle, Wash. 98105.

FILMS

The Edge. The MEDIHC (Military Experience Directed Into Health Careers) Program has announced a new, 20 minute, 16mm color film entitled "The Edge." Filmed at hospitals and health facilities in Missouri, actual employers present their views on utilizing medically trained and experienced veterans in their facilities. It's available on loan, or Mr. Piernot, MEDIHC Coordinator, will present the film to you or to a gathering of your associates. Send inquiries to MEDIHC, Wisconsin Health Council, Inc., Box 1109, Madison, Wis. 53701.

MEDICAL MEETINGS
POSTGRADUATE COURSES

his listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs conflict with others. Hospitals and clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal Office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Sept. 8–9: Wisconsin Allergy Society meeting.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Anesthesiologists. Marriott Inn, Brookfield. Info: Ruth A. Stoerker, MD, Secretary, 1300 University Ave., Madison 53706.

Sept. 14–15: Wisconsin Surgical Society Fall Meeting, Gateway Resort, Land O'Lakes.

Sept. 14-15: Wisconsin Regional Meeting, American College of Physicians, The Pioneer, Oshkosh.

Sept. 21-22: Postgraduate Conference on the Fetus and Newborn in High-Risk Pregnancy, University of Wisconsin Center for Health Sciences-Madison and the Wisconsin Perinatal Center-Southcentral Region, at Madison General Hospital, Madison.

Sept. 21–23: Wisconsin Radiological Society meeting, Sheraton Motor Inn, Madison.

Sept. 22: Second Annual North Central Clinical Cancer Conference, sponsored by the American Cancer Society, Marshfield Clinic, and Clinic Foundation, at Marshfield Senior High School Campus, 1401 East Becker, Marshfield. Program topic: "Current Concepts in Lung Cancer."

Sept. 29: Annual Congress: "Education in the 70s," Wisconsin Association of Professions, Inc., Holiday Inn, Eau Claire.

Oct. 2–5: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison (tentative).

Oct. 6: 19th Annual Fall Physicians Conference (Cancer Scrimmage) from 9 am to 12 noon at University of Wisconson-Madison Medical Center, SMI Bldg, Room 227. Sponsored by the American Cancer Society, UW Department of Continuing Medical Education, and the Division of Clinical Oncology.

Oct. 6: Wisconsin Society of Pathologists meeting, Bellin Memorial Hospital, Green Bay.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

Nov. 14: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Nov. 28-Dec. 1: Conference on the First Week of Life, sponsored by Wisconsin Association for Perinatal Care, Great Plains Organization for Perinatal Health Care, University of Wisconsin, Wisconsin State Department of Health and Social Services, and Division of Maternal and Child Health Services, at the Pioneer Inn, Oshkosh.

Dec. 6: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

1973 NEIGHBORING STATES

Sept. 15–16: Seminar on "Management of Sexual and Marital Inadequacy," sponsored by the Institute for Comprehensive Medicine, at Chicago Sheraton Hotel, Chicago, Ill. (Same program will be held Sept. 19–20 at Regency Hotel, Atlanta, Ga., and Sept. 22–23 at Royal Sonesta Hotel, New Orleans, La.) Info: William S. Kroger, MD, 9735 Wilshire Blvd., Beverly Hills, CA 90212.

Sept. 19-21: Clinical Hematology for the Internist: Pathophysiology Diagnosis and Treatment, American College of Physicians, Mayo Clinic, Rochester, Minn.

Sept. 29-Oct. 3: Advanced Workshop: Plastic Surgery of the Nose—Rhinoplasty and Reconstruction, Dept of Otolaryngology, U of Illinois Medical Center, Chicago, Ill.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 11-13: Fourth Annual Meeting on Antibiotics and Infection, University of Iowa, Iowa City, Ia.

Oct. 15-19: 59th Annual Clinical Congress, American College of Surgeons, Chicago, Ill.

Oct. 20-24: Annual Meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago, Ill.

Oct. 20–26: Annual Otolaryngologic Assembly of 1973, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Oct. 29-Nov. 1: 58th Annual Scientific Assembly, Interstate Postgraduate Medical Association, Palmer House, Chicago, Ill.

Nov. 12-14: Pulmonary Disease: Clinical, Immunological and Pathological Correlations, American College of Physicians, Mayo Clinic, Rochester, Minn.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 28-30: Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

1973 OTHERS

Sept. 6: Symposium—Implementation of the Recommendations of the Secretary's Commission on Malpractice, Cleveland Clinic Educational Foundation with American College of Legal Medicine, Cleveland, Ohio.

Sept. 16-20: Annual Meeting, American Association of Medical Clinics, Century Plaza Hotel, Los Angeles, Calif.

Sept. 27-29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Sept. 29: First Invitational Symposium on the Sero-Diagnosis of Cancer, cosponsored by the Laboratory Service, Naval Hospital, Bethesda, the College of American Pathologists (CAP), the American Society of Clinical Pathologists (ASCP), and the Armed Forces Radiobiology Research Institute (AFRRI), in the Naval Hospital Auditorium, National Naval Medical Center, Bethesda, Md. 20014.

Oct. 3–6: District VI, American College of Ob–Gyn, Holiday Inn Downtown, Des Moines, Iowa.

Oct. 7-Nov. 2: The Advanced Management Program in Health Care Administration, at University of Pennsylvania, Philadelphia, Pa., sponsored by The Leonard Davis Institute of Health Economics of the Wharton School.

Oct. 14-18: Pathology in Gynecology and Obstetrics, University of Colorado School of Medicine, Aspen, Colo.

Oct. 20-21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Oct. 21–24: District IV, American College of Ob–Gyn, El San Juan Hotel, San Juan, Puerto Rico.

Oct. 21-25: Annual Scientific Assembly, American College of Chest Physicians, Four Seasons Sheraton Hotel, Toronto, Ontario, Canada.

Oct. 22-24: Annual Convention, American College of Gastroenterology, The Biltmore Hotel, Los Angeles, Calif.

Oct. 23–26: World Conference on the Human Environment, Primosten, Yugoslavia, cosponsored by the World Medical Association in collaboration with the Union of Yugoslav Medical Societies, American Medical Association, and the United States Department of Health, Education, and Welfare.

☐ Copy deadline for MEDICAL MEETINGS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

MEDICAL MEETINGS . . .

1973 OTHERS

Oct. 25-27: Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, The Biltmore Hotel, Los Angeles, Calif.

Oct. 26-27: Postgraduate Course on Otolaryngology for the Family Practitioner, University of Miami School of Medicine, Department of Otolaryngology, Playboy Plaza, Miami, Fla.

Oct. 28–Nov. 4: District I and II, American College of Ob–Gyn, Acapulco Princess Hotel, Acapulco, Mexico.

Nov. 5–9: District VII and VIII, American College of Ob–Gyn, Hawaiian Village Hotel, Honolulu, Hawaii.

Nov. 8–10: Third National Conference of the Society for Computer Medicine, Denver, Colo. Info: Joseph M. Edelman, MD, President, Society for Computer Medicine, 200 Professional Center, 244 Peachtree Blvd., Baton Rouge, La. 70806.

Nov. 10-15: Annual Meeting, American Association of Blood Banks, Americana Hotel, Bal Harbour, Fla.

Nov 29–Dec 1: National Conference on Virology and Immunology in Human Cancer, Waldorf–Astoria Hotel, New York, N. Y. Sponsored by American Cancer Society and National Cancer Institute.

Nov. 29–Dec. 2: Annual Meeting, American Association for Clinical Immunology and Allergy, at The Hilton Palacio Del Rio Hotel, San Antonio, Tex. Info: Robert J. Brennan, MD, President-elect, AACIA, 3471 N. Federal Hwy., Ft. Lauderdale, Fla. 33306.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Oct. 7-10: AMA Woman's Auxiliary 1973 Conference, Chicago, Drake Hotel.

Oct. 10-14: AMA Board of Trustees and Committees, Chicago, AMA Headquarters.

Nov. 29-Dec. 1: AMA Board of Trustees, Anaheim, Calif.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Jan. 9: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Jan. 26–27: Council Meeting, State Medical Society of Wisconsin, Madison.

Feb. 28: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

1974 NEIGHBORING

Mar. 18-21: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

Apr. 15-19: Clinical Endocrinology: Recent Advances in Diagnosis and Treatment, American College of Physicians, Mayo Clinic, Rochester, Minn.

May 19-31: Cardiac Auscultation, American College of Physicians, Mayo Clinic, Rochester, Minn.

June 10-12: New Diagnostic and Therapeutic Modalities in Internal Medicine, American College of Physicians, University of Iowa, Iowa City, Ia.

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Jan. 2–5: Seminar in Pediatric Nephrology: Current Concepts in Diagnosis and Management, sponsored by the Division of Pediatric Nephrology, Department of Pediatrics, University of Miami School of Medicine, at Eden Roc Hotel, Miami Beach, Fla. Info: Div. of Continuing Education, UofM School of Medicine, P. O. Box 875 Biscayne Annex, Miami, Fla. 33152 (Tel. 305/350–6716).

Jan. 20: Colorado Academy of Family Physicians Annual Symposium, University of Colorado School of Medicine, Denver, Colo.

Jan. 21-26: 20th Annual General Practice Review, University of Colorado School of Medicine, Denver, Colo.

Feb. 10-16: Annual Meeting, American Society of Contemporary Ophthalmology, Fontainebleau Hotel, Miami Beach, Fla.

Feb. 10-16: Annual Meeting, American Society of Contemporary Medicine and Surgery, Fontainebleau Hotel, Miami Beach, Fla.

Feb. 17: Colorado Academy of Family Physicians Annual Symposium, Denver, Colo.

Feb. 18-23: 20th Annual General Practice Review (repeat of the January session), University of Colorado School of Medicine, Denver, Colo.

Mar. 20-21: Refresher Seminar in Pediatrics for Pediatricians and General Practitioners, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Mar. 25–27: Spring Meeting, American College of Surgeons, Houston, Tex.

May 8-9: Plastic Surgery for the General Surgeon, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

May 16-18: American Cancer Society's National Conference on Childhood Cancer, Fairmont Hotel, Dallas, Tex.

May 22-23: Advances in Antibiotics and Infectious Diseases, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

June 10-15: 20th Annual General Practice Review (repeat of the January and February sessions), University of Colorado School of Medicine, Estes Park, Colo.

July 1-5: Fifth International Seminar and Exhibition: "Rehabilitation of Disabled People—The New Era," British Council for Rehabilitation of the Disabled, The Central Hall Westminster, London, S.W.I.

Sept. 1–7: VII World Congress of Cardiology, Buenos Aires, Argentina. Info: American Heart Association, 44 East 23rd St., New York, NY 10010.

Oct. 21–25: Clinical Congress, America College of Surgeons, Miami Beac Fla.

1975 WISCONSIN

Apr. 7-8: Annual Meeting, State Med cal Society of Wisconsin, Marc Plaz Hotel, Milwaukee.

1975 OTHERS

Feb. 15-21: Thirteenth Congress, Par Pacific Surgical Association, Hilto Hawaiian Village Hotel, Honolul Hawaii.

* * *

Second Annual Course on Fetus an Newborn in High-Risk Pregnancy. Post graduate conference to be presented b the University of Wisconsin Center fo Health Sciences-Madison and the Wis consin Perinatal Center-Southcentral Re gion, at Madison General Hospital i Madison, Sept. 21-22. Course is agai open to 200 registrants (physicians an nurses) who are interested in acquirin some newer concepts and approaches t assessing the fetus and neonate of spe cific high-risk pregnancies.

Guest faculty includes Dr. Watson A Bowes, associate professor of obstetrics gynecology, University of Colorad School of Medicine, Denver. Twenty five members of the UW Perinatal Facul ty will actively participate.

Course will consist of formal presen tations, panel discussions, three separat obstetric and neonatal workshop session and question-answer periods. Many topic will be covered including Managemen of Premature Labor, Amniotic Fluid Analysis for Fetal Maturity, Inductio of Fetal Lung Maturity, and Intensive Care of the Premature Newborn.

Maternal and fetal-neonatal risks of Group B streptococcal infections will be discussed by a panel. Workshop sessions will be available to discuss such problems as fetal monitoring (antepartum and intrapartum), nutrition in pregnancy, management of premature rupture of membranes, neonatal surgical problems, cardiovascular problems of the newborn and maternal-infant relationships in the newborn period. A panel will discuss practical aspects of sexuality.

Further info and complete program: Dr. R. A. Barta, Fall Perinatal Course, 202 S. Park St., Madison Wis. 53715. Reduced fee for nurse-physician teams. Two hundred reserved seats for the Colorado-Wisconsin football game will also be available through this reservation.

State Medical Society of Wisconsin In-depth Teaching Programs: 1973-1974. Dates and locations for the programs are:

Wed., Nov. 14, 1973—Madison General Hospital

Thur., Dec. 6, 1973—St. Marys Hospital

Wed., Jan. 9, 1974—Madison General Hospital

Thurs., Feb. 28, 1974—St. Marys Hospital

Topics under consideration for presentation at the St. Marys group in December and February are: (1) Recent con-

epts and use of drugs in the manage-
ment of congestive heart failure. Medical
nd surgical management of angina
ectoris. (2) Current management of
cid peptic disease, surgical and medical.
Medical and surgical management of
allbladder disorders. (3) Update arth-
itis. Drugs used in the treatment of
rthritis. (4) Management of common
ram-positive infections—upper respira-
ory etc. Management of common gram-
egative infections.

Topics for presentation at the Madison
eneral group's November and January
essions are not yet finalized.

The University of Wisconsin Medical
chool will again participate by pre-
enting the basic science applications and
rogram for the various topics.

Further details will be announced as
lans are formalized.

TAP Institutes—Joint Commission on Accreditation of Hospitals. The 1973 Fall Schedule of the TAP Institutes, sponsored by state medical and hospital associations, has been announced. Designed by JCAH to meet the growing educational and informational needs of hospital trustees, administrators, and physicians; hence the "TAP" designation.

Institutes present information on medical care audit procedures, systems for delineating and granting of clinical privileges, and utilization review. Also reviewed are the legal obligations of hospitals in these areas.

During the first half of 1973 the Joint Commission conducted fifteen TAP Institutes. The average attendance of each was about 250. With this positive response, the JCAH has expanded its original schedule of Institutes and has begun a special series of local follow-up programs.

Dates and locations for the Fall TAP Institutes are:

Sept. 7-9: Harrisburg, PA
Sept. 14-16: Buffalo, NY
Sept. 21-23: Madison, WI
Sept. 28-30: French Lick, IN
Oct. 12-14: Cherry Hill, NJ
Oct. 19-21: Houston, TX
Oct. 26-28: Dallas, TX
Nov. 2-4: Augusta, ME
Nov. 9-11: Bismarck, ND
Nov. 16-18: Birmingham, AL
Nov. 30-Dec. 2: San Diego, CAL
Dec. 7-9: Phoenix, AZ

For sponsorship or registration information contact the Program Coordinator, Professional Education Program, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave., Chicago, IL 60611. Phone (312) 642-6061.

33rd Congress on Occupational Health—AMA. Sept. 17-18, The Benjamin Franklin Hotel, Philadelphia, Pa. Keynote address: Russell B. Roth, MD, President of AMA, Erie, Pa. Topics: Symposium—Occupational Safety and Health After Two Years, Chest Radiology in Occupational Pulmonary Diseases, Symposium—Workmen's Compensation A Year Later, Symposium—Antidiscrimination in Employment of Women, Priorities in Preventive Medicine—Where Are the Highest Yields? (distinguished guest lecture by Theodore F. Hatch, ScD, Emeritus Professor of University of Pittsburgh, Fitzwilliam, New Hampshire), Panel—Rehabilitation Nursing in Florida, and Panel—Diagnosis of Occupational Disease in General Medicine.

Advance registrations advised: $25 for AMA members or industrial nurses, $15 for medical students, $35 for all others. Congress Program is acceptable for credit toward AMA Physicians Recognition Award and for 12 elective hours by the American Academy of Family Physicians.

Columbia Hospital '73 Fall Clinic: Resolving Dilemmas in Hypertension. Tuesday, September 11, 9 am to 5 pm in Milwaukee. Topics: Hypertension-Definition-Epidemiology, Low Renin Hypertension, X-ray Diagnosis of Hypertension, Renovascular Hypertension Surgery for Renovascular Hypertension, Adrenal Surgery of Hypertension, Hpertension and Pregnancy, Tests Available to Practicing Physicians, Office Approach to Diagnosis, and Drug Therapy. Guest speakers: James C. Melby, MD, Professor of Medicine, Boston University School of Medicine and Director, Section of Endocrinology and Metabolism, University Hospital, Boston, Mass.; Sheldon G. Sheps, MD, Director of Hypertension Clinic, Mayo Clinic, and Associate Professor of Medicine, Mayo Medical Clinic, Rochester, Minn.; and Timothy S. Harrison, MD, Professor of Surgery, University Hospital, The University of Michigan Medical Center, Ann Arbor, Mich. Open to all physicians, residents, medical students, and interns. Please inform the Columbia Hospital Medical Education Department by Sept. 7 if you wish a luncheon reservation made for you. Phone: 414/964-5100, ext. 606.

58th Annual Scientific Assembly of Interstate Postgraduate Medical Assn. will be held at the Palmer House, Chicago, Oct. 29-Nov. 1. This meeting, primarily designed for Family Physicians and Internists, is an educational service open to any licensed MD or DO in the U.S. and Canada. The fee is $25 in advance or $40 at the meeting, consisting of 24 hours of "live" television, lectures, symposia, medical movies, and informal discussions. More than 1,200 physicians attend annually.

The 1973 Assembly will provide seven hour-long, patient-oriented television programs on "Ambulatory Care of Venous Diseases of the Extremities;" Oral Problems of Adults;" Asthma and Allergy;" "Sprains and Fractures;" "Office Procedures in Cardiac Diagnosis;" "Early Recognition of Depression in Office Practice;" and "Gait and Movement Disturbances as Clues to Diagnosis."

More than 50 physicians will take part in the meeting as lecturers. Special guest lecturers include William Arrowsmith, MD, New Orleans; Francis Braceland, MD, Hartford, Conn.; Howard Burchell, MD, Minneapolis; Michael DeBakey, MD, Houston; Rubin Flocks, MD, Iowa City; Edgar Gordon, MD, Madison, Wis.; Beverley Mead, MD, Omaha, Nebraska; and Robert Zollinger, MD, Columbus, Ohio.

Attendance provides educational credit for all members of the American Academy of Family Physicians and is also recognized by the American Medical Association for its Recognition Award attendance requirements.

Those wishing fuller details on the meeting and hotel registration forms should write to Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Association, P.O. Box 5445, Madison, Wis. 53705.

The Linking of Education and Health Care Delivery . . . an examination of the key elements in effective health care . . . will be the theme of the 24th Annual Meeting of the American Association of Medical Clinics, Sept. 16-20, at the Century Plaza Hotel, Los Angeles.

The three general sessions will be Education, Health Manpower and Health Care Delivery.

Keynote speaker, M. Roy Schwarz, MD, of the University of Washington School of Medicine, will address the group on the concept of Area Health Education. The discussion will focus on the need for constant reevaluation of medical education and the role group practice can play in providing students a better socioeconomic understanding of community medicine.

Health Manpower and the importance of physician recruitment and distribution will be the subject of a presentation by William R. Willard, MD, Dean of the College of Community Health Sciences at the University of Alabama. Emphasizing the critical relationship of health manpower and health education, the session will also direct itself to a consideration of the present status of the allied health personnel concept.

Merlin K. DuVal, MD, Vice-President for Health Sciences at the University of Arizona, will discuss the topic of Health Care Delivery and its importance not only to government and the general public but also to members of the profession. Stress will be given to the group practice approach toward community and regional health care needs. Alternative views of health care delivery will be presented by American Medical Association President, Russell B. Roth, MD, John W. Kauffman, Chairman of The American Hospital Association Board of Trustees, and Stanley S. Peterson, MD, President, American Federation of Physicians and Dentists.

Multiple workshop sessions on matters of concern to group practice physicians will be conducted. Topics to be included are: Allied Health Manpower; Physician Recruitment; Income Distribution and Fringe Benefits; Clinic Administration; Medical Records; Medical Auditing; and Integration of Capitation into Fee-for-Service Groups.

In addition to panel presentations on Community Level Medical Education, Patient Education, Role Expectations of Allied Health Personnel and the Impact of Politics on Medicine, seminars will be held for multi and single specialty groups to discuss problems relevant to various clinic sizes and specialties.

Other guest speakers highlighting the convention will be William I. Bauer,

CONTRIBUTIONS—CES FOUNDATION
June 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1973:

Unrestricted

4 SMS members voluntary contributions

Restricted

54 SMS members voluntary contributions—*Student Loans*
4 SMS members voluntary contributions—*Charitable—Disabled Physicians*
2 SMS members voluntary contributions—*Scientific Teaching—General*
1 SMS member voluntary contribution—*Kenosha County Student Loan Fund*
Mr. and Mrs. Wayne Brown—*Wisconsin Academy of Family Physicians Loan Fund*
Luxemburg Clinic—H. C. Rahr MD; L. J. Seward, MD; Prairie Clinic-Prairie du Sac; Gerald C. Kempthorne, MD; Ihor A. Galarnyk, MD; Apple River Valley Memorial Hospital; East Madison Clinic; T. R. Willett, DO; Wisconsin Rural Rehabilitation Corp.—*Medical Student Summer Externship Program*
Dodge County Medical Auxiliary; Mrs. Karel O. Cejpek; Mrs. Loren J. Driscoll—*Aesculapian Society*

Memorials

William B. Hildebrand, MD—*W. W. Hildebrand, Esq. and G. B. Hildebrand MD Memorial Account*
East Madison Clinic; The A. O. Reznichek Family; Miss Maryjo Reznichek; Miss Frances Reznichek—*Mrs. Teresa Zanna (C. C. Reznichek, MD Student Loan Fund)*
Jack T. Ryan; Nora D. Reuteman; Friends of D. P. MacRae—*Donald P. MacRae*
E. J. Nordby, MD—*Lars Gulbrandsen, MD, Anthony Hahn, MD, Hans Reese, MD*
Dr. and Mrs. Philip M. Wilkinson—*Francis Bachhuber, MD*
Grant County Woman's Medical Auxiliary—*Ernest Freymiller, MD*
Dr. and Mrs. W. W. Grover—*Roger C. Cantwell, MD*
Dr. and Mrs. J. S. Huebner—*Durand Benjamin, MD* □

MEDICAL MEETINGS . . .

MD, Director of Professional Standards Review for the Department of Health, Education, and Welfare, and the Honorable William R. Roy, MD, Democratic Congressman from Kansas and cosponsor of the House of Representatives' Health Maintenance Organization bill.

39th Annual Scientific Assembly of the American College of Chest Physicians will be held October 21-25 at the Four Seasons Sheraton Hotel, Toronto, Ontario, Canada. Three thousand physicians and allied health personnel are expected to attend the Assembly, which will feature five days of workshops, symposia, fireside conferences, and the presentation of 90 scientific papers.

Plans for opening day of the Scientific Assembly include clinic visits to 11 hospitals and teaching centers in Toronto. In addition, a one-day seminar for nurses and senior respiratory therapists on modern methods of managing patients with cardiorespiratory disease has been planned.

The College has arranged a special tour program for spouses of attendees.

Registration fee information and advance registration forms are available from the American College of Chest Physicians, 112 E. Chestnut St., Chicago, Ill. 60611.

Fourth Annual Meeting on Antibiotics and Infection will be held at the University of Iowa Thursday through Saturday, October 11-13. As well as 30 speakers from the University of Iowa Faculty, there will be six guest speakers: Dr. Saul Krugman of New York University; Dr. Gerald L. Mandell of University of Virginia Medical School; Dr. Sergio Rabinovich of the University of Southern Illinois; Dr. Jack S. Remington of Stanford University School of Medicine; Dr. John A. Washington II of the Mayo Clinic Medical School, and Dr. Arthur C. White of Indiana University School of Medicine. Inquiries should be made to Dr. Ian M. Smith, Department of Internal Medicine, University Hospitals, Iowa City, Iowa 52242. □

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Wisconsin Fund

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You get a comprehensive medical library to help you do your research. An editing service for your articles. Information and reports on medical and health subjects from any AMA department.

You get publications to keep you abreast of medical and health developments. *JAMA. American Medical News.* And *Prism,* the new socioeconomic journal.

You get the Physician's Placement Service to help you find a place to practice or locate an associate. And if you're a resident winding up your training, there's a special workshop to help prepare you for setting up your practice.

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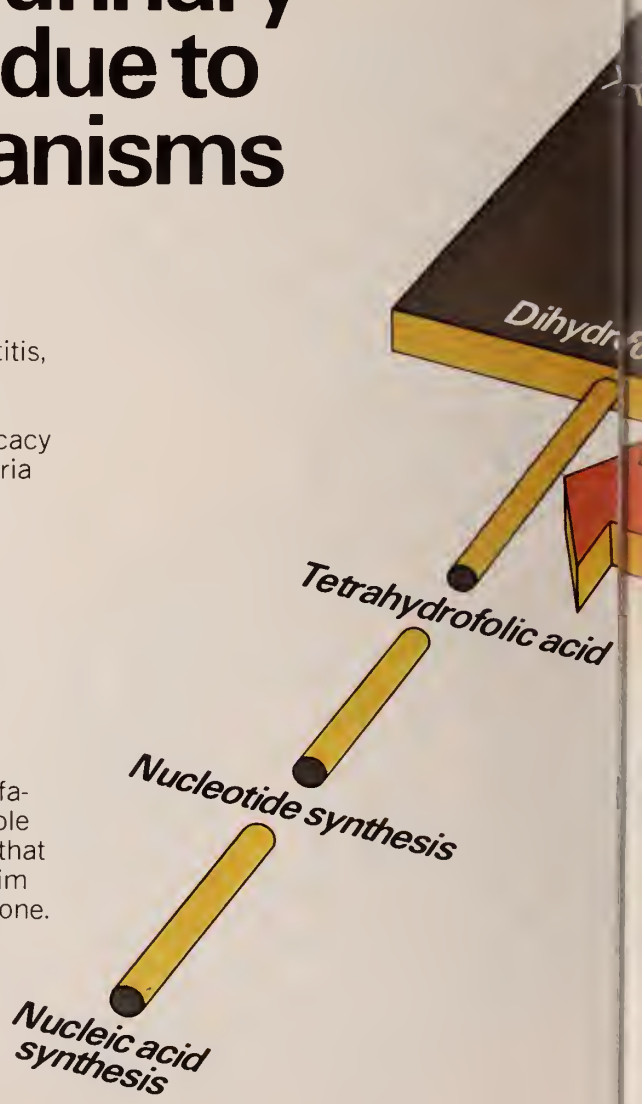

*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.

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interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

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for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

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Benefits-to-risks ratio permits higher dosage

For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

basic support in severe anxiety

Librium® 25 mg (chlordiazepoxide HCl)

1 capsule t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley N J 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

the wisconsin medical journal

official publication of

THE STATE MEDICAL SOCIETY OF WISCONSIN

SEPTEMBER 1973

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CORRECTION: The following item, now corrected, was incorrectly listed in the "Contents" of the August issue:

170 Bone Marrow Scanning in Hematological Disorders, by *Peter C. Raich, MD* and *Donald R. Korst, MD*, Madison

Scientific content is numbered consecutively throughout the twelve monthly issues of the volume

WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

Bobo's back at the big top

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100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
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If it doesn't work in a week, forget it.

ıportant Note: This drug is not a simple analgesic. Do ıt administer casually. Carefully evaluate patients be- re starting treatment and keep them under close su- ervision. Obtain a detailed history, and complete ıysical and laboratory examination (complete hemo- am, urinalysis, etc.) before prescribing and at fre- ıent intervals thereafter. Carefully select patients, oiding those responsive to routine measures, contra- dicated patients or those who cannot be observed fre- ıently. Warn patients not to exceed recommended ɔsage. Short-term relief of severe symptoms with the nallest possible dosage is the goal of therapy. Dosage ıould be taken with meals or a full glass of milk. Sub- tute alka capsules for tablets if dyspeptic symptoms ccur. Patients should discontinue the drug and report ımediately any sign of fever, sore throat, oral lesions ymptoms of blood dyscrasia), dyspepsia, epigastric ain, symptoms of anemia, black or tarry stools or other vidence of intestinal ulceration or hemorrhage, skin re- ctions, significant weight gain or edema. A one-week ıal period is adequate. Discontinue in the absence of a ıvorable response. Restrict treatment periods to one eek in patients over sixty.
dications: Acute gouty arthritis, rheumatoid arthritis, ıeumatoid spondylitis.
ontraindications: Children 14 years or less, senile pa- ents; history or symptoms of G.I. inflammation or ul- eration including severe, recurrent or persistent dys- epsia; history or presence of drug allergy, blood yscrasias, renal, hepatic or cardiac dysfunction; hy- ertension; thyroid disease, systemic edema, omatitis and salivary gland enlargement due to the rug; polymyalgia rheumatica and temporal arteritis, atients receiving other potent chemotherapeutic gents, or long-term anticoagulant therapy.
Varnings: Age, weight, dosage, duration of therapy, ex- tence of concomitant diseases, and concurrent potent hemotherapy affect incidence of toxic reactions. Care- ılly instruct and observe the individual patient, espe- ıally the aging (forty years and over) who have ıcreased susceptibility to the toxicity of the drug. Use ɔwest effective dosage. Weigh initially unpredictable enefits against potential risk of severe, even fatal, re- ctions. The disease condition itself is unaltered by the rug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-H(10/71)

For complete details, including dosage, please see full prescribing information.

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sleep for 7 to 8 hou without need to repeat dosage

No sleep r cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pa given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer r time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re dosage during the night.

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Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other able hypnotic.

When your evaluation of insomnia indicates the need for a sleep ication, consider Dalmane—a single entity nonnarcotic, nonbiturate agent proved effective and relatively safe for relief of mnia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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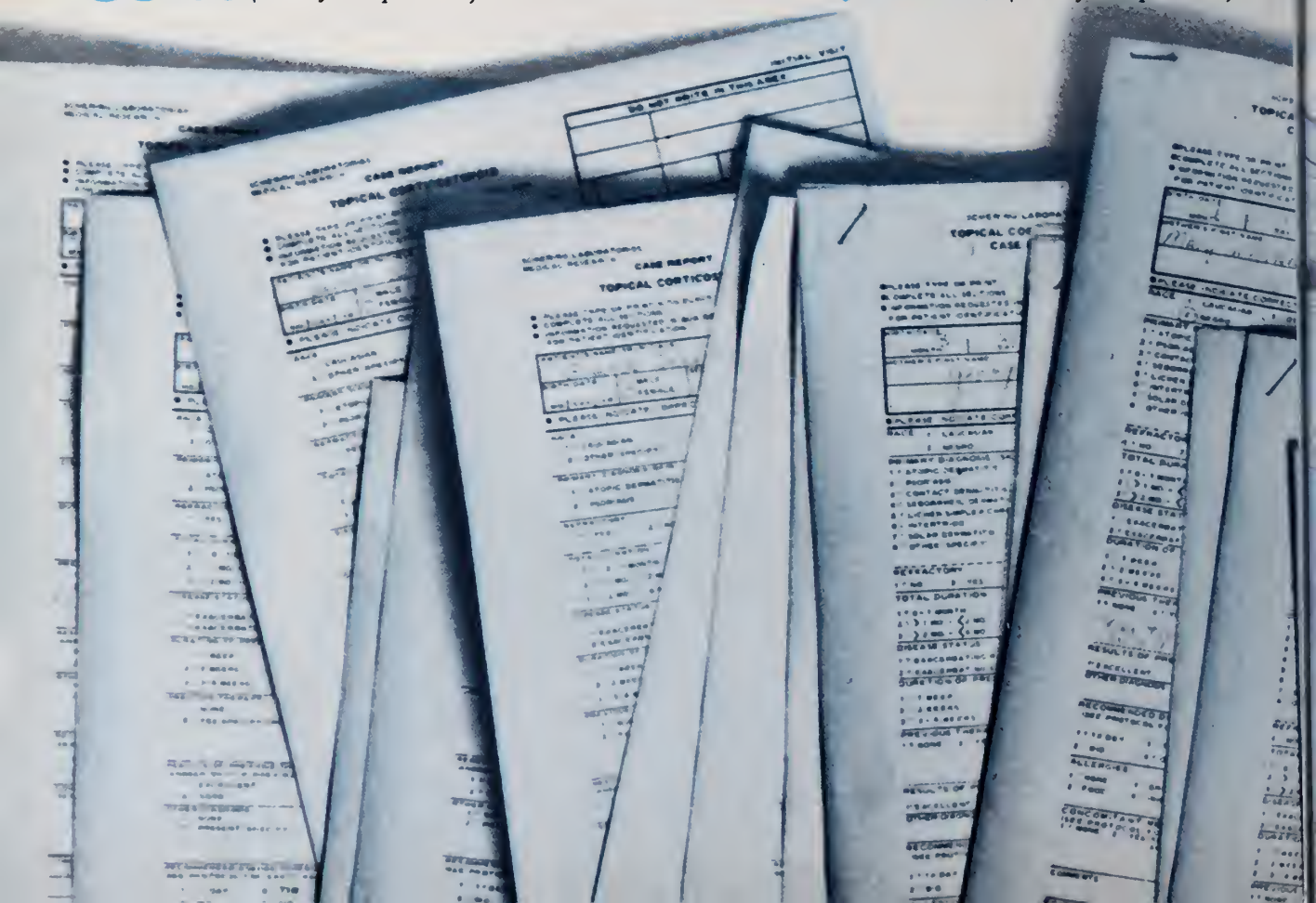
A topical steroid that has clinically succeeded

in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic ecze *(231 of 251 patients)*[1]



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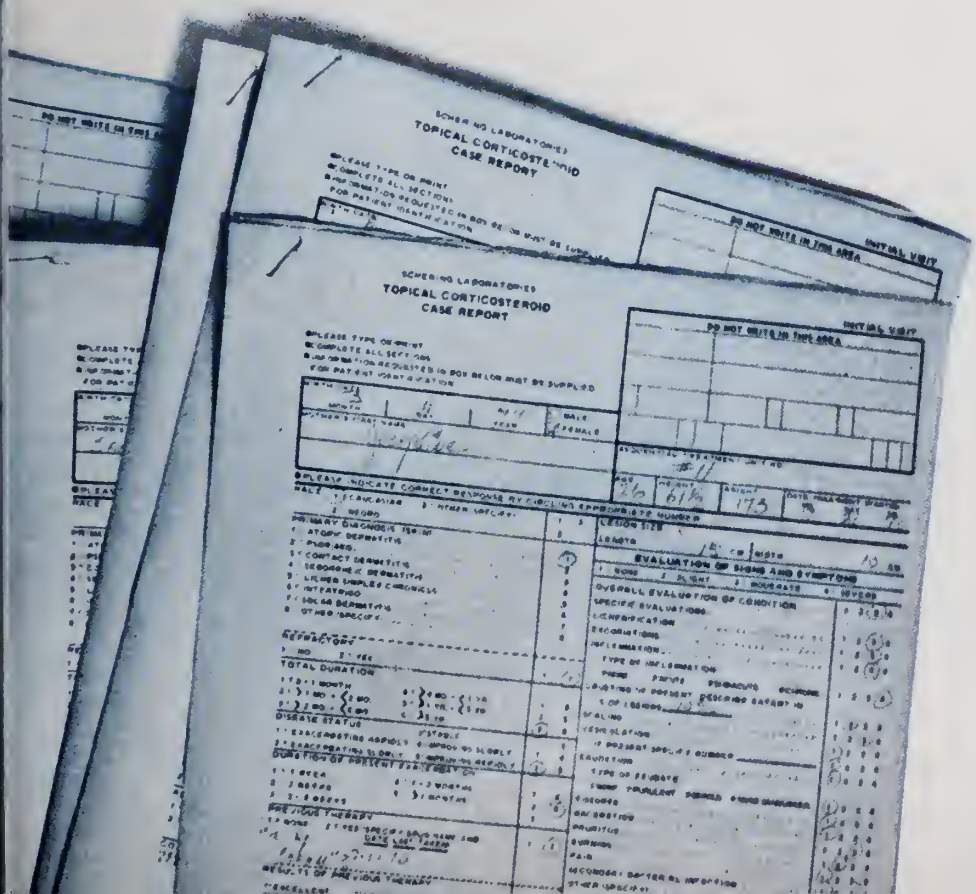
betamethasone valerate (0.1%) Cream/Ointment

Plus economy *B.i.d. dosage often found effective!*
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis
(81 of 84 patients)[1]



CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11$_\beta$,17,21-trihydroxy-16$_\beta$-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Nooyn, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLR-43

ROCHE announces new BACTRIM™

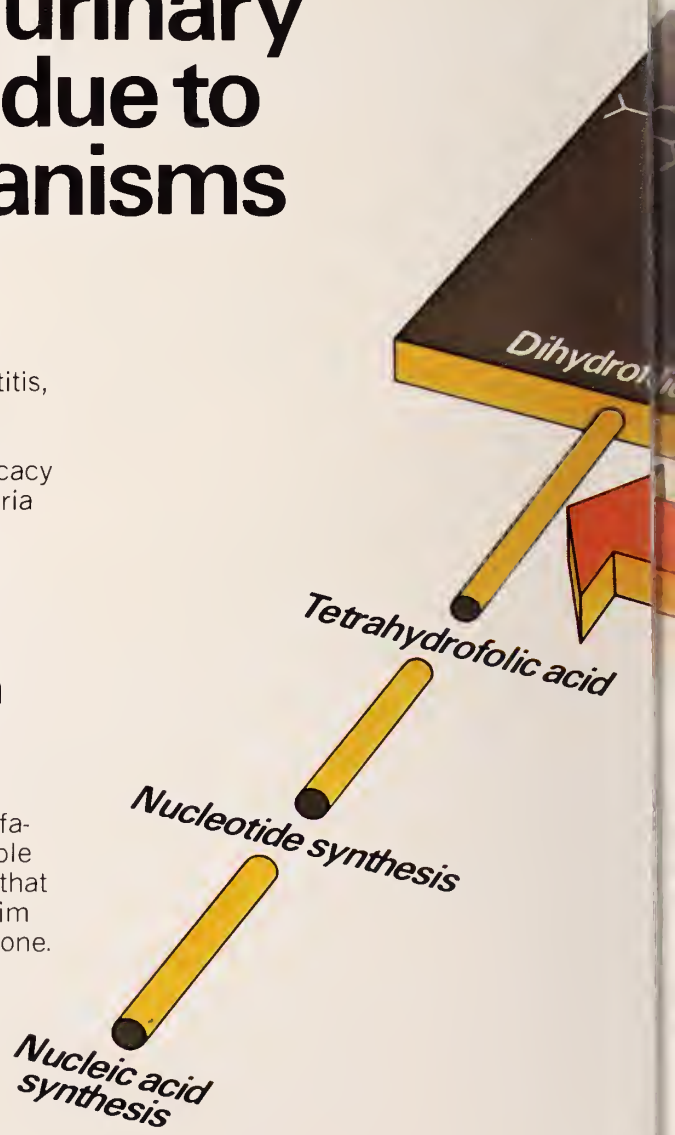
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.

ROCHE

interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

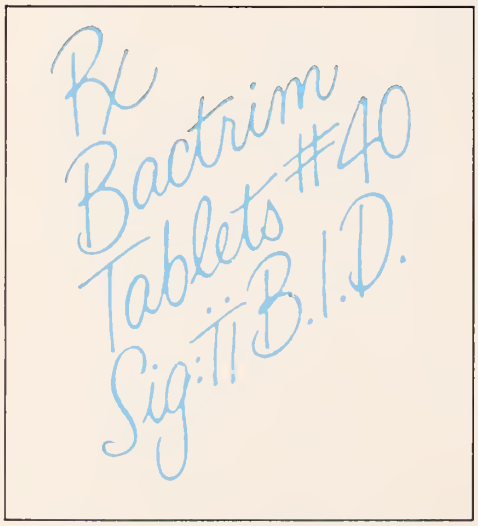
Although Bactrim demonstrated impressive clinic results, it is important to note that the incidence clinically significant adverse effects was low, mair nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

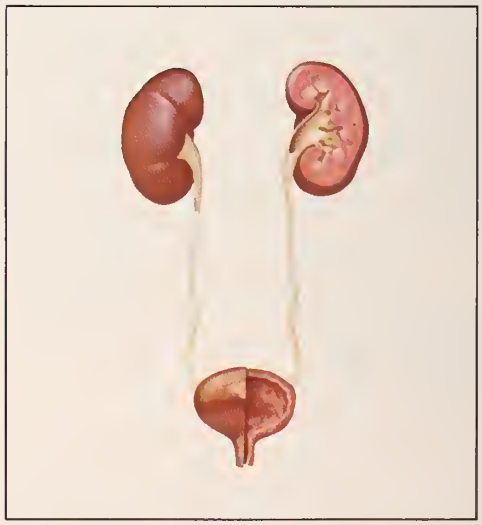
Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses w careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatmer of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hou for 10 to 14 days; no loading dose required.

* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
† 4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

omplete Product Information:

escription: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg imethoprim and 400 mg sulfamethoxazole.

rimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. is a white to light-yellow, odorless, bitter compound with a molecar weight of 290.3.

ulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is n almost white in color, odorless, tasteless compound with a mocular weight of 253.28.

ctions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis dihydrofolic acid by competing with *para*-aminobenzoic acid. rimethoprim blocks the production of tetrahydrofolic acid from dirofolic acid by binding to and reversibly inhibiting the required nzyme, dihydrofolate reductase. Thus, Bactrim blocks two conecutive steps in the biosynthesis of nucleic acids and proteins ssential to many bacteria.

vitro studies have shown that bacterial resistance develops more owly with Bactrim than with trimethoprim or sulfamethoxazole one.

vitro serial dilution tests have shown that the spectrum of antiacterial activity of Bactrim includes the common urinary tract athogens with the exception of *Pseudomonas aeruginosa*. The folwing organisms are usually susceptible: *Escherichia coli, Klebella-Enterobacter, Proteus mirabilis* and indole-positive proteus ecies.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

acteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
scherichia oli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
roteus spp. ndole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
roteus nirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
lebsiella-nterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

uman Pharmacology: Bactrim is rapidly absorbed following oral ministration. The blood levels of trimethoprim and sulfamethoxale are similar to those achieved when each component is given ne. Peak blood levels for the individual components occur one four hours after oral administration. The half-lives of sulfamethazole and trimethoprim, 10 and 16 hours respectively, are relaely the same regardless of whether these compounds are adminered as individual components or as Bactrim. Detectable ounts of trimethoprim and sulfamethoxazole are present in the od 24 hours after drug administration. Free sulfamethoxazole d trimethoprim blood levels are proportionately dose-dependent. repeated administration, the steady-state ratio of trimethoprim sulfamethoxazole levels in the blood is about 1:20.

lfamethoxazole exists in the blood as free, conjugated and pron-bound forms; trimethoprim is present as free, protein-bound d metabolized forms. The free forms are considered to be the erapeutically active forms. Approximately 44 percent of trimethrim and 70 percent of sulfamethoxazole are protein-bound in the od. The presence of 10 mg percent sulfamethoxazole in plasma creases the protein binding of trimethoprim to an insignificant gree; trimethoprim does not influence the protein binding of famethoxazole.

cretion of Bactrim is chiefly by the kidneys through both glomerir filtration and tubular secretion. Urine concentrations of both famethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together in Bactrim, neither sulfamethoxazole nor trimethoprim affects urinary excretion pattern of the other.

lications: Chronic urinary tract infections (primarily pyelonephri- pyelitis and cystitis) due to susceptible organisms (usually coli, *Klebsiella-Enterobacter, Proteus mirabilis,* and, less frently, indole-positive proteus species).

portant note: Currently, the increasing frequency of resistant organs is a limitation of the usefulness of all antibacterial agents, espelly in the treatment of chronic and recurrent urinary tract infections.

ntraindications: Hypersensitivity to trimethoprim or sulfonamides. egnancy and during the nursing period (see Reproduction dies).

rnings: Deaths associated with the administration of sulfonamides ve been reported from hypersensitivity reactions, agranulocyto- aplastic anemia and other blood dyscrasias. Experience with nethoprim alone is much more limited, but it has been reported interfere with hematopoiesis in occasional patients. In elderly ients concurrently receiving certain diuretics, primarily thiaes, an increased incidence of thrombopenia with purpura has en reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

ENFEOFF—To the Physician

THIS CURIOUS TERM, spoken as 'EN-F•F' comes out of the middle ages. It means to hand over as a fief, or in a larger sense to surrender entirely. It referred first to land but easily extended to life and liberty of the person holding the fief. We are still within that feudal concept so far as medicine is concerned, although not of course so far as medicine is practiced. And like in the land and life fiefs of the middle ages, we slowly change.

The responsibility of healing has been given over almost entirely to physicians, for some centuries now. Some question if medicine is the best instrument, preferring chiropractic or Christian Science, or ortho molecular psychiatry. But society as we know it has "enfeoffed" us, as doctors of medicine, with the basic right, hence responsibility, for the burden of human disease. We can do the cutting and the prescribing and the waiting, but we must bear the burden too: careful work, fully informed on newest methods, and we must care what happens to our trusting patients. It seems clear, and it is direct to expect, from us care, caution and cure. Most all of us readily agree we will do these expected things and scatter unto the four winds to find a small town, or a large group of pathologists, or a state hospital, or a university teaching position. We consider we have apprenticed ourselves well, learned much, and are now ready to give from this, and hopefully to receive in turn our fair share of worldly goods.

For most physicians who practice this highly humane and ethical way, that is the end of the thinking. That this function of society should be surrendered completely to us seems real and most reasonable. We accept our enfeoff with equanimity, and think no more.

Last month I spoke of the shadowy events that determine some parts of our lives. This month I'll call to your attention some of the shadowy, or ignored, aspects of being a physician, which may contribute to the growing unfavorable image we have in the public eye. To accept our little "fief" is all well and good. It fails to take into account the larger aspects of distribution of medical care, its cost both directly and in time lost (is that none of our affair), plus many other current cries. These will be discussed in later editorials from the view of the body politic and from the view of the public itself. Now we must ask what the doctor sees.

First off, some doctors do not see any problem at all. They execute their enfeoffment with loving care and superb skill but fail to address themselves to the other broader questions. It's not that they are unintelligent, for the problems of medicine require rigor. But somehow all those extra things are seen, if at all, as secondary to the "real" thrust of medicine. Besides, if a fellow wants he can always find a doctor, somewhere, someplace; and goodness knows how much charity he gives; and sure, cost is a problem but it usually comes out all right.

Beyond the non-seeing physician are those who see the problems clearly but call them distinctly outside their ken (or should I say "fief"). Now, in a strict sense these fellows are right, as they reflect what they were taught to do in medical school. And the medical schools were in turn enfeoffed by society to produce this very medical model. They are interested in problems of medical delivery but no more so than they are interested, as good citizens, in tax problems, school districts, and elections.

And some go a step beyond this, to insist that every man is master of his own ship and that he is not his brother's keeper. He is ready, willing, and even eager to help *anyone* who speaks up for help or who seeks him out. But these persons simply do not believe that it is their call in life, or their right, to go further. And they do not.

The last group, perhaps no more right and certainly no more holy than the first three, are those who do take all the so-called public health aspects of medicine into the accounts of their own practice. Whether they are merely aware, or intensely dedi-

cated, does not matter here, for they stand as a group so far as their feelings are concerned.

Now which ever notion of enfeoffment seems correct to you, you most surely know others who fall elsewhere. Someone may even think of a fifth category! But each group has a different experience. Those toward the first group have been honored since the days of monarchy, while the public health has struggled for a poor last in medical esteem. Today there seems to be some reversal of this, toward more respect among physicians for the public health view (and perhaps the full public-responsibility view). As there comes a shift from outside, we feel differently. Our confidence in ourselves is shaken when our special view of the . . . (medical) . . . world is no longer the vogue. What we do at such times, your sense of history will tell you. We were offended by the first medicare notions and showed our spunk. We reacted, it seems to me, perfectly honestly and straight forwardly. But we reacted strictly in terms of our notion of the charge given us by our colleagues and our medical schools. By today's standards, that judgment seems wrong. It did not seem so then, but only relative to our, perhaps unconscious, ideas of who we are.—RH

GUEST EDITORIAL

A New Direction for Science?

WITH SO MUCH GOING on at various levels of planning for national health insurance and for assuring quality control of health services, it is not easy for the everyday medical practitioner to keep a clear head and to remain calm. The adversary method seems to prevail in this pre-legislative arena from which ultimately laws will be drawn. The majority of physicians remain aloof from this ferment.

Although a small number of politically-oriented physicians has moved into action, energized by a sense of alarm over the growing prospects for a regimented medical system, the average physician remains dutifully committed to his work and hopefully will rely upon the wisdom of his organizational leaders. He trusts that an increasing comprehension on the part of the medical consumer will achieve two things: provide quality care to all citizens and yet do so on a non-punitive and reasonable fiscal basis. As yet, this dual objective remains tantalizing beyond the grasp of third-party payers, hospital comptrollers, and practitioners of medicine.

In an attempt to achieve financial feasibility, there is increasing scrutiny of the appropriateness of treatment procedures and worse, insistence upon their conformity with procedural guides and disease-management protocols. Such trends may spell demoralization of therapy.

The rank-and-file of medical practitioners, including specialists, shudder at visions of a monolithic "big-brother," authoritarian, and absolute. The present example of the Federal Drug Administration as it has functioned during recent years poses but a pygmy problem as contrasted with the gigantic effect of mandated authority in an overall medical-administrative bureaucracy.

Last February a group of 21 prominent American scientists and university administrators charged that U. S. medicine was falling behind due to the "procedures by which new drugs are evaluated and approved for use in this country," and that the drug regulatory system "too often stifles creativity and escalates costs of research, perpetuates a continuing decline in the number of new drugs entering the market in this country, and may be depriving the physician of agents beneficial to patient care." The charges were made in a letter to Representative Paul G. Rogers, chairman of the House subcommittee on Public Health and Environment. The group called on Congress to conduct a "full-scale review of the effect of the 1962 Drug Act and regulations on the practice of medicine and the conduct of academic and industrial drug research."

To make treatment as "scientific" as we might consider the intrinsic function or physiology of an organ, such as the liver, the lung or the heart, would be a grave mistake. It could largely dehumanize the practice of medicine.

From time immemorial a salutary fact has periodically been restated by medical titans (i.e., Hippocrates, Hunter, Osler, Middleton). Their collective but concise philosophic conclusion has been that treatment and healing in all their aspects are a delicate combination of science and art. To debase the art by requiring practitioners to follow a stilted, regimented modus operandi would inevitably lead to devitalization of medicine if not to its destruction as one of the traditional professions.

Thus far, the other professions, particularly religion and law, have been permitted their internal ethicomoral determinations free from coercive legislative intervention. Their present level of cultural meaningfulness is not presently under fire as is the honesty, integrity, and altruism of medicine.

If the law were "supervised" or "monitored," its natural growth would be stunted and it would become a process of fiat and arbitrariness. And even more obviously one does not seek to make religious

dicta "scientific." Neither is law a cut-and-dried procedural tactic. These professions also contribute to the advance of our culture and to the relief of human suffering. They do this by maintaining an apt blend of logic, rationality and objectivity, while providing for emotional, sentimental, and traditional aspects of human need as well.

More specifically, we may gather compelling evidence that the healing process itself is distinctly more than ingesting the "correct" medication or carrying out a technically "correct" surgical procedure. To create a censoring, monitoring, bureaucratic behemoth in order to produce what is termed "quality" medical care will be a conceptual mistake. Healing and cure remain as indefinable as language and communication.

A curative process is set in motion by multiplicity of factors. We are unable to lay hold of the exact formula. Looking upon the history of medicine as a groping forward from scientific darkness to increasing understanding of "scientific" processes, we have only to read, however, the most erudite scientific journals on genetics, immunophysiology, and the degenerative diseases, such as atherosclerosis and cardiovascular disorders as well as neoplastic disease, to appreciate that however rapidly the frontiers of knowledge are advancing, they still are as remote from precise and predictable results as man in a physical sense is remote from the distant stars.

It would seem, nonetheless, that medicine by decree, through a hierarchy of bureaucratic controls which would render the practitioner a minion to ill-conceived procedural guides and authority-determined protocols, is in the offing. This type of medical care would lack the spontaneity, individuality, and basic interdisciplinary freedom which is so essential to health-creating freedom of choice. America prospered from its frontier days to its industrial might only because it was free and its individual enterprises were likewise. Various foreign nations withered and atrophied because theirs were not. And the same can be said of American-applied science, of which medicine is an example. — ALBERT L. FISHER, MD
La Crosse

Physician, Heal Thyself

"RESOLUTION 10 REQUESTS that means be developed to insure that meals at AMA-sponsored meetings adhere to modern nutritional concepts. Your Reference Committee is sympathetic with efforts to reduce the toll of atherosclerotic cardiovascular disease. Evidence was presented, however, that previous attempts at controlled diets at medical meetings have been unsuccessful. Menu selection, in the opinion of your Reference Committee, should remain a voluntary decision on the part of the individual physician. We do urge, however, that special diets be available at AMA-sponsored meal functions for those who request them." Quoted from Reference Committee H, page 4, AMA House of Delegates (A-73)

Five Digits For Medical Integrity

THE AMA HOUSE OF DELEGATES, meeting in New York in June, approved a resolution calling on the AMA to begin educating physicians, insurance companies, and government agencies about the advantages of using the language of *Current Procedural Terminology—Third Edition* for reporting all services provided by a physician. The House-approved resolution was a compilation of four others submitted by individual state medical societies, indicating that many physicians want *CPT*-3 to come into general use.

Testimony given before a reference committee in support of the House resolution established that no one is more qualified to describe what a physician does than the physician himself. *CPT*-3 is organized medicine's definition of medical practice. It is the physician's answer to the other definitions of medical practice that have been issued by forces outside the AMA. The general feeling at the New York convention was that in an era of PSROs it would be foolish for physicians to allow some outside group to set up the definitions under which their peers shall judge them. Physicians have a good chance of avoiding outside definition only if they begin using terms from *CPT*-3, rather than some other codification, to report all their services.

CPT-3, the result of months of intensive work by a ten-man editorial board and consultants from each of the specialty societies, describes over five thousand procedures in strict medical terminology and provides each with a five digit computer code. It establishes beyond question what is a medical procedure and what is only a service offered by non-physician health-care professionals. In the words of AMA trustee Dr. Richard Palmer, "*CPT*-3 is the most broadly based, physician-oriented document in many years."

Copies of *CPT*-3 are available through AMA headquarters in Chicago.—ROBERT PERKINS, Philstan Corporation, Elm Grove, WI 53122

Where Will It End?

In a carefully prepared paper in this issue, Doctors Sheldon R. Braun and Marvin L. Birnbaum have described one particular complication which results from two paradoxical factors in our modern world. As motor power increases, so do motor accidents. And as medical science advances, so does our ability increase to prolong the life of persons through critical stages. While both of these facts have many points in their favor, the serious physician can study this paper on "The Adult Respiratory Distress Syndrome" with profit. It illustrates that even with healthy advances in technology and in medical skills, we must be forever vigilant for unexpected complexities of these changes. The paper is commended to your careful reading. — RH □

LETTERS

Re: Article on EPSDT

TO: The Medical Editor—The Department of Health and Social Services Medical Assistance Program for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) of Medicaid eligibles under age 21 is administered by the Division of Family Services. The Division of Family Services has agreed that the Division of Health shall contract with local providers for the screening phase of the program. (See *WMJ*, June 1973, page 34a of the Green Sheet)

The screening is expected to be carried out by non-physicians and, therefore, will not include a "physical examination." No one is to be screened unless a personal physician is designated for referral and follow-up for diagnosis and treatment as indicated. All screening results will be furnished to that physician. Each screening agency will be asked to obtain from the appropriate county medical society a list of primary care physicians who are willing to accept new patients on Medicaid. A screenee who does not have a regular physician may on request be given the names of three physicians from the list.

In some areas of the state where physicians and other health care providers are not present in large numbers, there well may be a problem. There is no ready answer and suggestions would be appreciated.

There has been excellent cooperation from the physicians in Dane County while working out the guidelines for the pilot program. Suggestions from other physicians are necessary and important as the department attempts to achieve statewide compliance with federal law in the next few months.

Richard Biek, MD
Wisconsin Division of Health
Madison, Wisconsin

Re: Editorial "Conundrum"

TO: The Medical Editor—Concerning the "junk mail." (WMJ, July 1973, page 10) Do you know that the coordinator of junk mail is The American Medical Association? Look at the label that some of your junk mail bears and you will find a code number on most of it. Look at your *JAMA* and you find that code number is your AMA mailing code number. This is the way your name gets on everybody's mailing list.

The only way you can cut it out is to put "no promotional mailing" on your annual AMA medical journal questionnaire card or write to them directly, insisting on acknowledgement that your name has been struck from the promotional mailing list.

There is, as always, a price to pay for freedom from junk mail. You will have to write for the quality journals that you want such as *Hospital Practice* and *Medical Economics*. You will have to request the *PDR*. They will not mail you one automatically. Hardly anymore samples will cloud your morning mail except perhaps something that you have specifically requested.

John B. Weeth, MD
La Crosse, Wisconsin

TO: John B. Weeth, MD—You are so right about the source of the mailing lists. Because of the thousands of changes of address of United States physicians every month, there could be no other current listings.

The resulting volume of "throw-aways" hurts not only the state medical society journals but the *JAMA* as well. Consequently, on July 14 I had already asked the Council of our State Medical Society to request through the AMA House of Delegates or whatever channel is proper, that the AMA stop supplying these mailing lists.

Thank you for your interest and suggestions.

V. S. Falk, MD
Medical Editor
Edgerton, Wisconsin □

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	**Vaccine(s)**
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

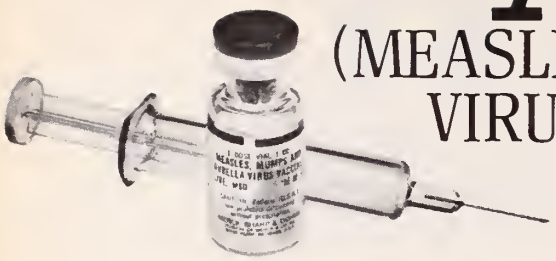
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

Just what do you get for your AMA dues?

You get a package of personal and professional services and benefits you've probably never been fully aware of.

You get insurance programs at a cost considerably lower than those purchased on an individual basis. A $250,000 Excess Major Medical Policy. Group Life. Disability Income Insurance. Professional Liability Insurance (in co-sponsorship with your state society.) Then there's the AMA Members Retirement Fund.

You get a comprehensive medical library to help you do your research. An editing service for your articles. Information and reports on medical and health subjects from any AMA department.

You get publications to keep you abreast of medical and health developments. *JAMA. American Medical News.* And *Prism*, the new socioeconomic journal.

You get the Physician's Placement Service to help you find a place to practice or locate an associate. And if you're a resident winding up your training, there's a special workshop to help prepare you for setting up your practice.

All these are just a few of a broad spectrum of benefits and services you get for your dues. But even more important, you get a strong and effective national spokesman to represent you, your interests and your views.

Join us.
We can do much more together.
American Medical Association
535 N. Dearborn St./Chicago, Ill. 60610

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by forn AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated ir crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients...

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econon impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inter ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nece sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmacis made in the absence of clinical know edge of the patient, could expose hi to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothir in the pro-substitution argument tha offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledg about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will nee expert knowledge of no more than 2

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should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 9 SEPTEMBER 1973

The Adult Respiratory Distress Syndrome

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Madison, Wisconsin

AN INCREASING NUMBER of patients who have been victim to some acute physical stress fit into a clinical setting which is manifest by progressive hypoxemia and pulmonary infiltrations. This picture is called the Adult Respiratory Distress Syndrome (ARDS). Although the pulmonary changes are for the most part reversible, the outcome often is fatal.

There are two principal reasons for the increasing incidence of the ARDS: (1) The number of persons injured in accidents which involve high decelerative forces is increasing; (2) the ability to support critically ill patients is improving and hence a sufficient period of time may pass for the syndrome to become manifest. The ARDS frequently complicates the treatment of, or is the result of, shock,[1] sepsis,[2] fat embolization,[3] cardiopulmonary bypass,[4] congestive heart failure, aspiration and/or viral pneumonia.[1]

The clinical picture is quite uniform.[1] One to two days after a traumatic event, progressive dyspnea and tachypnea occur. Often examination of the chest is unrevealing. Occasionally, diffuse bronchial breath sounds and/or end-inspiratory râles may be heard. Roentgenographic examination of the chest may show diffuse or patchy parenchymal infiltration. Measurements of arterial blood gases and acid-base status indicate progressive hypoxemia (pO_2 <60 mmHg) and often uncompensated respiratory alkalosis (pCO_2 <35 mmHg; pH> 7.44). Attempts to treat the increasing hypoxemia with supplemental oxygen are encouraging initially but may be doomed to failure as the pathologic processes progress. Once initiated, the process progresses rapidly and if untreated, results in a fatal outcome. However, with adequate support the pathologic picture regresses to relatively complete resolution.

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Case 1

A 15-year-old gravida 1, para O female was admitted to the hospital with no history of previous pulmonary disease. Admission physical examination was within normal limits. On the day of admission a "salting-out" procedure was performed and uterine contents were delivered within 36 hours of the saline instillation. Within the next 24 hours there occurred a decline in hematocrit from 35 to 25, and over a period of 2 1/2 hours one unit of whole blood and one unit of packed cells were administered. Four to five hours after completion of the transfusions, the patient noted the onset of a dry cough, dyspnea, and chills. Two hours later she had a fever of 38.5 C (101 F), diffuse cracking râles, and hematuria. Hematocrit was 38%. Arterial pO_2 was 42 mmHg and the oxygen saturation (SaO_2) was 78%. The arterial pCO_2 was only 25 mmHg and pH was 7.43. Chest x-ray film showed confluent infiltration of both lungs (Fig 1A). Oxygen delivered by nasal prongs at a flow rate 8 L/min resulted in an increase of the arterial pO_2 to 66 mmHg and a SaO_2 of 90%. Appropriate sputum, urine, and blood cultures were taken and chloramphenicol (0.5 gm every 8 hours) and hydrocortisone (1.0 gm every 6 hours) were administered. Figure 2 summarizes the hospital course. She was placed in a chest shell (Fig 3) and the inside of this shell was held at a pressure of 20 cm H_2O below atmospheric. With this therapy, the arterial pO_2 promptly increased to 129 mmHg and the oxygen saturation (SaO_2) increased to 99%. As indicated in Figure 2, this allowed the inspiratory oxygen flow to be substantially decreased without impairment of oxygen delivery. With this therapeutic approach, the clinical picture rapidly reversed and with it, the roentgenographic and gas exchange abnormalities. After five days mechanical support was discontinued, and without supplemental oxygen administered the arterial PO_2 was 101 mmHg. Before discharge on the seventh day, the chest x-ray film and gas exchange measures had returned to within normal limits (Fig 1B). No pathogenic organisms were isolated from cultures taken during febrile period.

Case 2

A 50-year-old man with multiple injuries sustained in an automobile accident was transferred to this hospital. On admission blood pressure could not be detected.

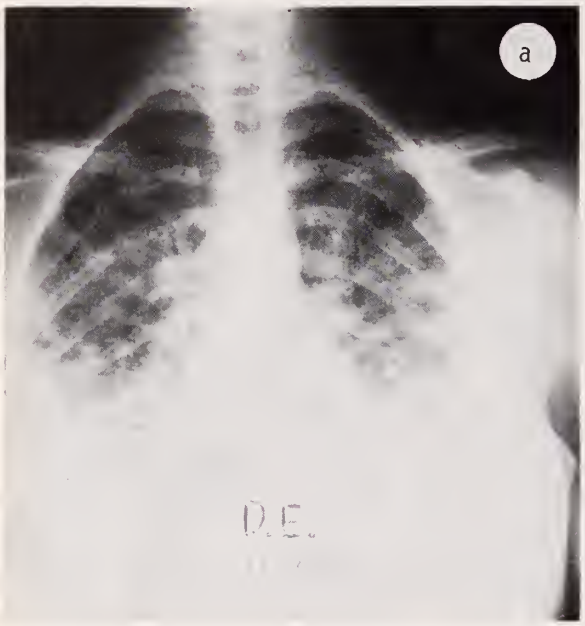


Figure 1A—Chest film of patient in Case 1 soon after the onset of dyspnea following the transfusion reaction.

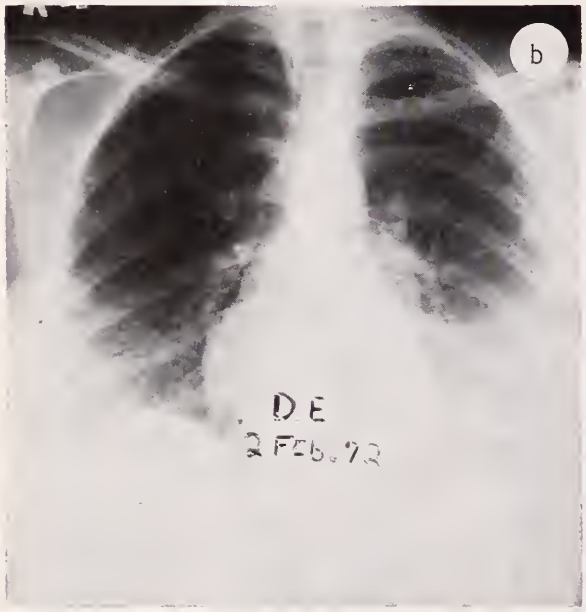


Figure 1B—Chest film of patient in Case 1 upon recovery.

Immediately after the rapid intravenous infusion of 5000 ml of lactated Ringer's solution, the blood pressure was detected at 90/0 mmHg and within 30 minutes following the start of the infusion, the blood pressure was 130/70. Injuries included (Fig 4) a fracture of the left acetabulum, displacement of the head of the left femur medially into the pelvis, a fracture of the superior

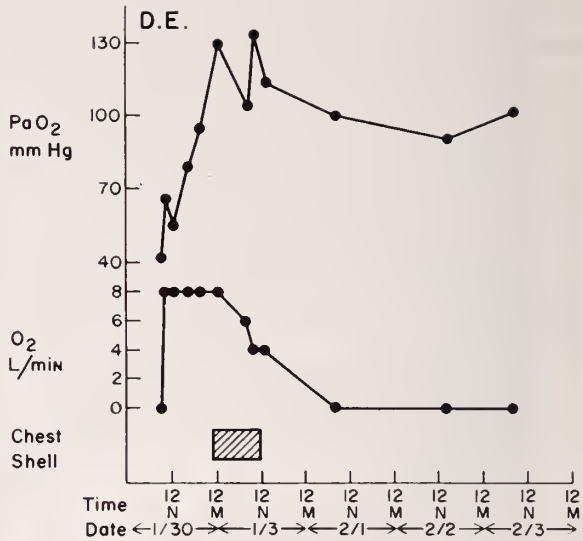


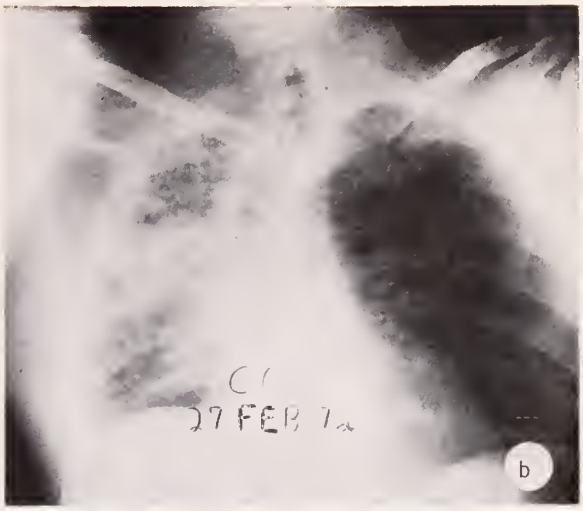
Figure 2—Hospital course of patient in Case 1 showing arterial pO_2 (PaO_2), O_2 flow by nasal prongs (l/min) and the time the chest shell was used.

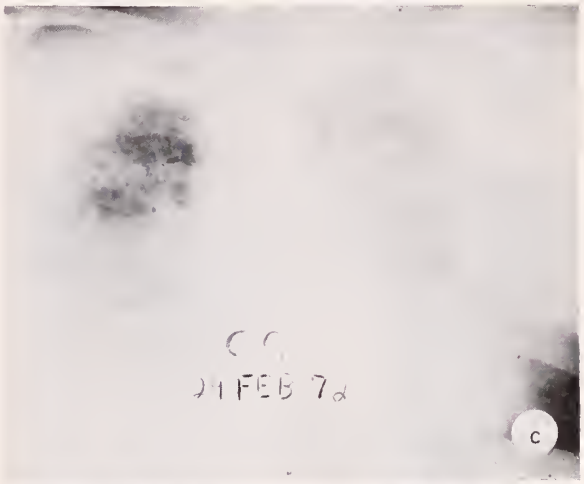
Figure 3—The chest shell being demonstrated by a technician.

Figure 4—Roentgenogram of patient's pelvis in Case 2 showing extent of injury.

ramus of the right pubic bone, a fracture of the left wing of the sacrum, and a contusion of the urinary bladder. Examination of the chest and chest x-ray film (Fig. 5A) were within normal limits. Under general anesthesia, an intertrochanteric screw was placed into the left femur.

On the second hospital day, the patient had a sudden episode of hemoptysis. Examination of the chest remained unremarkable but a chest x-ray film (Fig 5B) revealed alveolar infiltration in the right upper lung field. No subsequent episodes of hemoptysis occurred, and his pulmonary status remained stable until the third hospital day when he became progressively dyspneic. Examination showed large tidal volume breathing at a rate of 16/min, and cyanosis of the nail beds and lips. An arterial pO_2 was 30 mmHg, pCO_2 was 34 mmHg, and pH was 7.49. Administration of 90-100% oxygen by non-rebreathing face mask increased the arterial pO_2 to 48 mmHg. Chest x-ray film





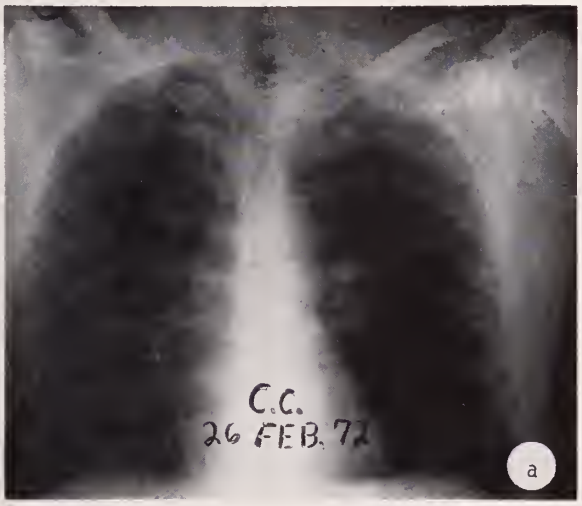


Figure 5—Chest films of patient in Case 2 on (a) day of admission, (b) on the second hospital day after the onset of hemoptysis, (c) on the third hospital day after noting presence of cyanosis, and (d) on the day of discharge.

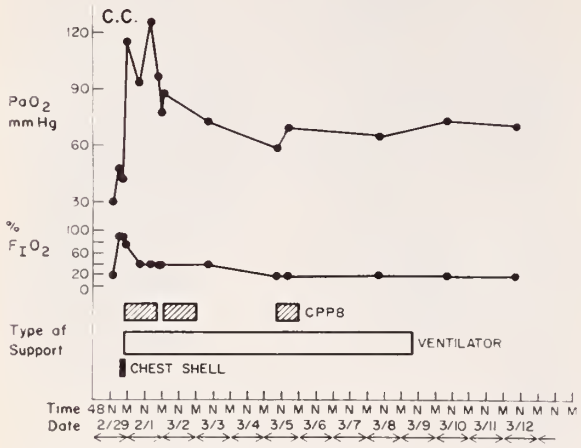


Figure 6—Patient's hospital course in Case 2 indicating arterial pO_2 (PaO_2), the inspiratory O_2 concentration (F_IO_2) and the type of respiratory support used.

Figure 7—Normal chest film of patient in Case 3 after onset of ARDS.

(Fig 5C) revealed diffuse interstitial infiltration predominantly in the left lung. An attempt to increase the arterial pO_2 using the chest shell described above was not successful, and the patient was intubated with a nasotracheal tube (Portex, No X79) and ventilation was supported with volume-cycled ventilator (Ohio, 560). By holding the airway pressure continuously positive relative to the atmosphere (continuous positive pressure breathing) there occurred an increase in the arterial PO_2 to 116 mmHg. The hospital course is summarized in Figure 6. Continuous positive pressure breathing (CPPB) was required for eight consecutive days and was effective in maintaining an adequate arterial pO_2 (>60 mmHg) while using inspiratory oxygen concentrations

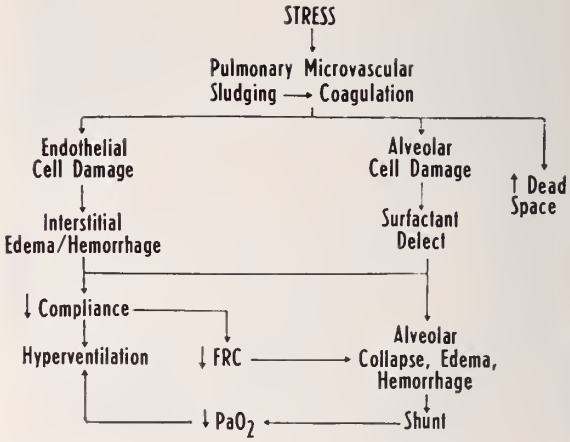


Figure 8—Diagram of pathophysiology of the ARDS.

of 30-40%. The nasotracheal tube was removed on the 13th hospital day and the patient was discharged on the 44th hospital day. By this time the chest x-ray film had returned to normal (Fig 5D). Mild hoarseness was present after extubation but had cleared by the time of discharge from the hospital.

Case 3

A 68-year-old male was admitted to the hospital shortly after sustaining multiple injuries in an automobile accident. Injuries included comminuted fractures of the distal right femur and proximal left tibia and fibula, and simple fractures of his mandible and manubrium.

On admission, vital signs, examination of chest, and chest roentgenogram were all within normal limits. He was placed in balanced skeletal traction and intravenous administration of 5% alcohol in 5% dextrose and water was begun. He remained alert and stable through the first hospital day, but on the second hospital day he became increasingly dyspneic and confused. Examination of the chest remained unremarkable. Arterial hypoxemia and hyperventilation became manifest (PaO_2 = 50 mmHg, $PaCO_2$ = 28 mmHg and pH = 7.50). Administration of oxygen by nasal prongs at 6 L/min failed to correct either the hypoxemia or hypocapnia (PaO_2 = 57 mmHg, $PaCO_2$ = 25 mmHg and pH = 7.56).

His condition continued to deteriorate and he was transferred to the intensive care unit. A nasotracheal tube (Portex Z79) was inserted and ventilation was assisted with a volume cycled ventilator (Ohio, 560) set to deliver an inspiratory O_2 concentration of 40% at 4-5 cm H_2O continuous positive pressure. Clinical improvement was promptly manifest.

On the third hospital day arterial pO_2 improved to 97-119 mmHg but as manifest by a low arterial pCO_2 the hyperventilation persisted. However, combined compliance of the lung and chest wall progressively decreased (0.062 to 0.035 L/cm H_2O) and late on the third hospital day hypoxemia again became manifest (pO_2 = 45).

Support with 10-14 cm H_2O CPPB was necessary to maintain adequate oxygenation at inspiratory oxygen concentrations of 30-40%. Such support was continued until the tenth hospital day when ventilatory support was no longer required. The interstitial edema characteristic of ARDS could not be demonstrated by chest x-ray film at any time in the early hospital course (Fig 7).

Discussion

Figure 8 outlines the probable pathophysiologic mechanisms involved in the genesis of the ARDS. Regardless of the nature of the stress which predisposes an individual to the development of the ARDS, it seems that changes occur in the microvascular structure of the lung. This, in turn, is followed by damage to the vascular endothelial cells and to the pneumocytes of the lung. Alterations in the metabolic functions of these cells results in the accumulation of fluid in the pulmonary interstitium and in alterations in the character of the surfactant which is important in the maintenance of alveolar stability. The lungs become heavily laden with fluid and tend to become atelectatic. Thus, the ability of the lungs to carry on gas exchange is impaired and results in arterial hypoxemia.

The exact morphologic changes which occur in the lung following the initiating stress differ somewhat depending upon the nature of the "triggering stress." When the process has been initiated by a direct blow to the thorax, diffuse interstitial hemorrhage (pulmonary contusion) often results. The intrapulmonary bleeding usually reaches its maximum intensity within the first 24 hours following the injury and is followed by the accumulation of inflammatory cells within the hemorrhagic area. The appearance of the lungs at this later stage has been described as "hepatization" of the lungs.[5] When the initial triggering event is related to extrathoracic trauma, sepsis, shock, fat embolization, or cardiopulmonary bypass, sludging and eventual stasis of pulmonary capillary blood flow probably occur and result in a morphologic pattern which is suggestive of diffuse intravascular coagulation in the lungs.[6] These changes coupled with agglutination of leukocytes in the pulmonary capillaries result in alterations in the permiability of the capillary endothelium, extravasation of fluid into the pulmonary interstitium[7] and swelling of the pneumocytes of the lungs.[8] This process reaches its maximal intensity three to five days following the initial insult.

Regardless of whether the principal morphologic change is related to interstitial hemorrhage or edema, the pathophysiologic changes which are responsible for the clinical manifestation are essentially the same. Increased interstitial water, regardless of its form, causes the lungs to become more resistant to inflation; i.e., they become "stiffer" or less pliant. This process is amplified by the changes which may occur in pulmonary surfactant.

Decreased pulmonary compliance has several important effects. First, because the lungs are more resistant to inflation, the work required to inspire a given quantity of air is increased. This increased work of breathing may be perceived by the patient as dyspnea and he tends to overbreathe or hyperventilate. Thus, especially early in the disease process, it is characteristic for the arterial pCO_2 to be low rather than elevated. Furthermore, this hyperventilation results in an alkalotic pH. Hyperventilation was present in each patient in this review.

The second major effect of a stiff or less pliant lung is that the volume of air remaining in the lung at the end of a normal expiration (FRC—functional residual capacity) is decreased. This occurs because the stiff lung pulls harder against the chest wall than does a normally pliant lung. Therefore, some areas of the lung which are normally ventilated and perfused, collapse and are no longer ventilated. However, perfusion of these atelectatic areas by venous blood persists. Blood passing such non-ventilated or collapsed alveoli can not become oxygenated. In the pulmonary venous system, this poorly oxygenated blood mixes with oxygenated blood from well ventilated areas and the resultant arterial mixture is low in oxygen or hypoxemic. This phenomenon is called an intrapulmonary shunt. The degree of hypoxemia in the arterial blood is therefore an indication of the severity of the intrapulmonary shunt. Since this shunted blood never comes in contact with alveolar gas, the arterial blood cannot be fully oxygenated even when breathing 100% oxygen.

The severe hypoxemia encountered in these patients may be corrected, at least in part, by returning the FRC to relatively normal levels. Thus, alveoli which are collapsed are re-expanded and the intrapulmonary shunt is decreased. This can be accomplished in several ways. In Case 1, the chest wall was pulled outward to a larger volume by applying sufficient constant negative pressure around the chest and upper abdomen to counteract the increased pull by the stiffer lungs. A chest curass connected to a vacuum cleaner operated at a speed sufficient to produce 20-30 cm H_2O negative pressure was used. The response was prompt and the method was non-invasive. A similar attempt was made in Case 2 but was not successful. Because the man had a muscular chest wall, it was not possible to significantly bias the chest wall to a larger volume. Instead, a second method was used to increase the resting volume (FRC). The airway pressure was not allowed to return to zero during expiration and

hence the lungs could not return to a lowered volume.

Holding the airway pressure positive relative to the atmosphere is called positive-end-expiratory pressure (PEEP) or continuous positive pressure breathing (CPPB) and can be achieved by setting a dial on the new ventilators (Ohio 560, Bennet MA-1) or by placing the expiratory port of the older ventilators under water seal. Continuous positive pressure breathing was successful in maintaining adequate arterial O_2 concentrations at relatively low inspiratory oxygen concentrations in Cases 2 and 3.

In the past, oxygen has been administered with relative impunity. Now it is clear that the use of high concentrations of oxygen in the inspired air may result in damage to the lungs which may be irreversible. High concentrations of O_2 at the alveolar level are apparently toxic to the pneumocytes and hence to surfactant production and results in interstitial hemorrhage and edema which is similar to that which occurs in ARDS. Thus, the long-term use of high inspiratory concentrations of oxygen may further compound the pathophysiology of ARDS and should be avoided. Therefore, in order to minimize the possibility of producing O_2 toxicity, an adequate arterial pO_2 must be maintained at as low and inspiratory O_2 concentration as possible.[9]

It seems now that every critically ill patient eventually receives supplemental steroids and this also follows in the ARDS.[9] The efficacy of steroids in the treatment of the ARDS is not clear. Steroids tend to stabilize cellular membranes and may stabilize the lysosomal membranes thereby preventing the release of cellular enzymes. In addition, they may minimize interstitial edema. Little conclusive evidence for beneficial effects of supplemental steroids has yet been offered. Some investigators feel[10,11] steroids are useful when the ARDS is secondary to fat embolization or viral pneumonia but not when it is the result of other causative factors.

Similarly, anticoagulation with heparin is used by some workers and is avoided by others. Conclusive evidence to support either approach is lacking. If the pathophysiologic process is initiated by diffuse intravascular coagulation (DIC) or sludging within the pulmonary capillaries, the use of heparin seems obvious. However, since DIC in the lung seems conjectural at present and because many cases of ARDS are complicated by acute gastrointestinal hemorrhage, heparin should be administered with caution. While some investigators believe that heparin may have significant value in the treatment of fat embolization, others feel anticoagulation with heparin is contraindicated.[12]

Finally, since the ARDS is associated with interstitial pulmonary edema, over-hydration should be avoided. Instead patients who have a high potential to developing ARDS should be kept on the dry side.[1,7,9,13] Some workers administer low doses of diuretic agents to help assure under-hydration.

The most important concept relative to ARDS is that the entire process is reversible if the patient receives adequate supportive care. While the specific modalities of therapy evolve, there is present in today's armamentarium sufficient tools to allow most patients whose courses are complicated by the Adult Respiratory Distress Syndrome to survive.

ACKNOWLEDGMENT: The authors wish to thank Mrs. Regina Parks for her secretarial assistance.

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Chloroform Parties

WILLIAM W. STORMS, MD, University of Wisconsin Medical Center, Madison, Wis: *JAMA* 225:160 (July 9) 1973

Chloroform ingestion was reported in a 19-year-old boy from Central Wisconsin; this was an accidental ingestion during a party at which chloroform was being inhaled. The patient suffered severe, transient hepatic injury. Renal impairment was not seen; mild, reversible cerebellar signs were noted, however. The number of young adults who participate in these chloroform-sniffing parties is unknown, but the potentially lethal consequences should be stressed to all young adults. □

A Review of Mycoplasma Pneumoniae Infections in the Milwaukee Area

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MYCOPLASMA PNEUMONIAE or Eaton agent has been shown to be a major cause of cold hemagglutinin positive primary atypical pneumonia.[1] Generally such infections with *M. pneumoniae* are not considered to be highly contagious, and intimate contact over a period of several weeks is required for the infection to spread among members of a family with a known index case.[2] The spread of the disease in such families is especially extensive among children. Recently we have observed *M. pneumoniae* infection of the seven children of a family in which the oldest child had developed the index case. An epidemiological study of this family occurrence was undertaken concurrent with a review and reevaluation of the significance of *M. pneumoniae* as a cause of respiratory infections in the Milwaukee area.

Extensive epidemiological studies have been made of the role of *M. pneumoniae* in acute respiratory illness by Evans, et al[3] on university students, Chanock, et al[4] on Marine recruits and Foy, et al[2] on infections in families. These studies indicate that the nature of the illness associated with this agent may vary from asymptomatic infections to severe pneumonia. The most prevalent clinical syndromes encountered include: primary atypical pneumonia, bronchitis, laryngitis, and upper respiratory infections. Although no symptoms are considered diagnostic of infection, the most predominant findings include: headache, malaise, fever, sore throat, and a cough.

Variable results have been reported on the frequency of developing pneumonia as a result of infection with *M. pneumoniae*. Chanock and coworkers reported that only one out of every 15 to 30 Marine recruits infected with *M. pneumoniae* developed clinical pneumonia. However, studies by Foy and coworkers showed that over 70 percent of family contacts develop clinically detectable pneumonia, although the majority frequently were not ill enough to seek medical help. Infections with *M. pneumoniae* are not considered critical and rarely become fatal. Normally it is spread by droplet infection with a variable incubation period from 8 to 35 days, the median period being 2 to 3 weeks. Infections have been found in all months of the year, although outbreaks have been most frequently reported in the fall or in early winter.

Materials and Methods

The clinical cases in this study are limited to those for which acute and convalescent serum samples were received in our laboratory from hospitals or physicians in the Milwaukee area. All of these cases have been screened by the microcomplement fixation (CF) procedure,[5, 6] for the following respiratory viruses: influenza A, influenza B, Q. fever, psittacosis, adenovirus, respiratory syncytial virus and *M. pneumoniae*. Before 1965 only the cold hemagglutination (CA) technique[7] was employed for diagnosis of primary atypical pneumonia. From 1966 to the present the *M. pneumoniae* CF test has been used routinely in our virus respiratory panels, while the CA test has been used only sporadically, usually in conjunction with the *M. pneumoniae* CF test.

In interpreting our serology results, we have classified as confirmed cases of *M. pneumoniae* those cases showing a four-fold or greater increase in either complement-fixing antibody or cold hemagglutinin. Those symptomatic patients with an unchanged titer of 1:64 or greater, or a four-fold or greater decrease in titer for either complement-fixing antibody or cold hemagglutinin were interpreted as presumptive for recent cases of *M. pneumoniae*. The mean titers for the cases with high unchanged titers were 1:444 for complement-fixing antibody and 1:320 for cold

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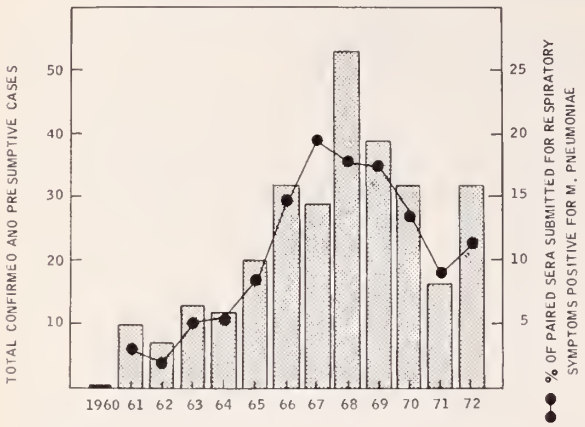

FIGURE 1. ANNUAL OCCURRENCE OF M. PNEUMONIAE

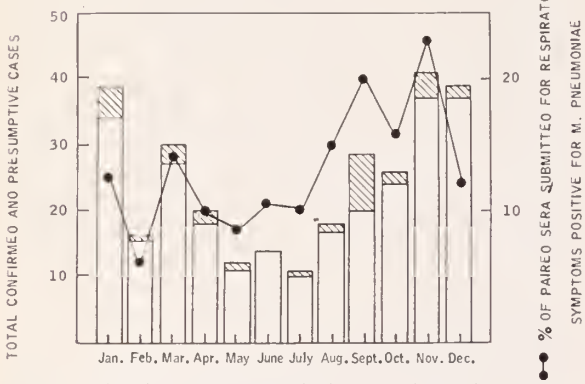

FIGURE 2. MONTHLY OCCURRENCE OF M. PNEUMONIAE FOR THE PERIOD 1961 - 1972: 1972 CASES

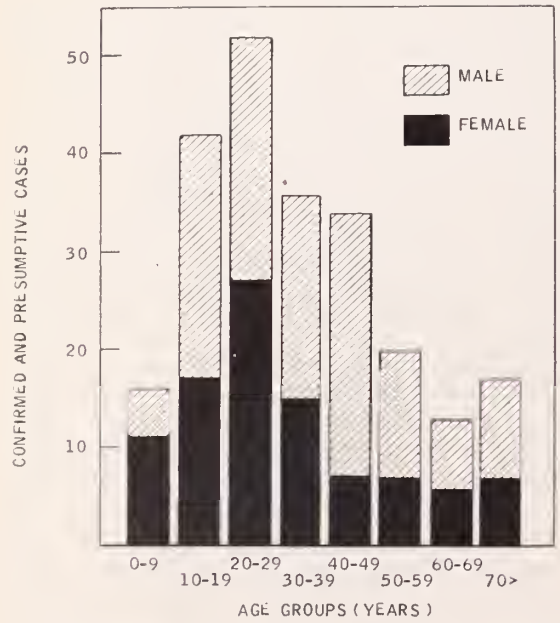

FIGURE 3. SEX AND AGE DISTRIBUTION OF PERSONS INFECTED WITH M. PNEUMONIAE DURING THE PERIOD 1965 - 1972

hemagglutinin. The mean extent of time between collection of the acute and convalescent serum specimens for all the included cases was 17.2 days.

The acute specimens for the family outbreak of primary atypical pneumonia were collected in our laboratory on referral of the family physician. The convalescent specimens were drawn in the home of the family where the epidemiological study was conducted. Clinical symptoms and diagnosis were furnished by the family physician. X-ray films on the children were taken at the Milwaukee Health Department, Chest Observation Clinic. Throat washes were obtained at the same time as the convalescent serum samples. Minimal Essential Medium with Hank's Salts, 1% fetal calf serum, and no antibiotics was used for the throat washes. The throat washes were kept on wet ice for approximately one hour before inoculation of tissue culture cells and PPLO agar plates containing 1% PPLO serum fraction. Cell cultures of WI-38, HEp-2, HeLa, VERO, WISH, and primary Green Monkey kidney were incubated at 36 C and observed for 10 days for possible viral cytopathic effect. The PPLO plates were incubated anaerobically at 37 C and observed for 30 days before being discarded.

Results

Historically in the early 1960s Eaton agent was considered to be a virus, and since then it has been traditionally included in the diagnostic tests of our Virology Division. A review of our diagnosed virus respiratory infections for the Milwaukee area has previously been reported for the period 1955-1965.[8] During this period, the incidence of *M. pneumoniae* appeared to be relatively low, although an increase from 1960 to 1965 was reported. Since 1966, *M. pneumoniae* has assumed a prominent role in respiratory infections in the Milwaukee area (Table 1). While only sporadic cases of atypical pneumonia were reported earlier, 214 cases have been diagnosed since 1966, of which 78 percent have

TABLE 1—*Comparison of confirmed and presumptive repiratory cases for the periods 1955-1965 and 1966-1972*

Type of case	1955-1965 (2428 paired sera)			1966-1972 (1648 paired sera)		
	No.	% of paired sera	% of diagnosed cases	No.	% of paired sera	% of diagnosed cases
Influenza	250	10.2	40.5	322	19.5	51.2
Adenovirus	181	7.5	29.3	41	2.5	6.5
Psittacosis	68	2.8	11.0	34	2.1	5.4
Q fever	29	1.2	4.6	1	0.1	0.2
M. pneumoniae	62	2.6	10.0	214	13.0	34.0
Respiratory syncytial	28	1.1	4.5	17	1.0	2.7
Total	618	25.4	100.0	629	38.2	100.0

been specifically demonstrated to be due to *M. pneumoniae* by the CF test. These represent 13 percent of total respiratory cases tested and 34 percent of the diagnosed respiratory virus infections. Only influenza has been demonstrated to occur with greater incidence during this period.

An analysis of the annual number of diagnosed cases of *M. pneumoniae* infections (Fig. 1) demonstrates that the increase has been gradual, progressive and cyclic. A survey of the major hospitals in the Milwaukee area in 1961 revealed that the incidence of primary atypical pneumonia during the preceding five years was very sparse. A slight progressive increase can be noted during the next five years. Since 1966, however, the number of confirmed and presumptive cases of *M. pneumoniae* has averaged over 30 cases per year with a peak occurrence of 53 cases in 1968. Most of the significant cases in 1968 occurred at the beginning of the year rather than the end when an outbreak of influenza A2/Hong Kong occurred. When both the number of diagnosed cases of *M. pneumoniae* and the percent of paired respiratory sera that were positive for *M. pneumoniae* are considered, it appears that the peak years for *M. pneumoniae* infections were 1967 and 1968.

A comparative study of the monthly occurrence of these infections from 1961-1972 (Fig 2) demonstrates that the agent is endemic in the population throughout the year, but a significant increase in the number of cases can be noted during the months of November, December, and January. Also a greater proportion of respiratory diseases in the fall appears to be due to *M. pneumoniae* since the percentage of significant cases increases during this period.

The sex and age distributions of persons with confirmed or presumptive cases of *M. pneumoniae* are given in Figure 3. These data cover the years 1965 through 1972 when approximately 75 percent of all cases were diagnosed by the complement fixation procedure. The sex distribution for all cases over this period is males 57 percent and females 43 percent. For cases in which both sex and age were available, Figure 3 indicates that the greatest number of significant cases was in the age group 20 to 29 years, followed by the group from 10 to 19 years.

A review of the clinical impressions submitted by the attending physician on the 234 cases since 1965 also is interesting: 98 cases were simply diagnosed as respiratory infections; 73 cases as pneumonia; 18 cases as fever of undetermined origin, and 9 cases as bronchitis. Thus, approximately 85 percent would conform to typical clinical infections. Unexpected and of special interest were 12 cases in which we had evidence of *M. pneumoniae* infections associated with pericarditis, myocarditis, myocardial infarction, or congestive heart failure. Infection also was associated with 3 cases of clinical encephalitis.

A compilation of the clinical information available on those patients with a possibility of virus involvement in cardiopathies shows the following. Since 1963, 149 sets of paired sera have been submitted for cases with cardiopathies. Of these cases 42, or 28.2 percent, have had a significant antibody titer to some virus. The largest number of diagnosed cases was 17 for *M. pneumoniae* (6 active cases, 5 presumptive, and 6 suspicious with unchanged CF titers of 1:32) followed by 14 for influenzas A and B, 6 for adenoviruses, 2 for psittacosis, 1 for parainfluenza 3, 1 for respiratory syncytial virus, and 1 heterophile positive. Ten of the *M. pneumoniae* cases were diagnosed as myocarditis, 3 as pericarditis, 3 as myocardial infarction, and 1 as congestive heart failure. A comparison of the *M. pneumoniae* and influenza cases indicates that in general those affected have been males (24 of 31 cases) but of a lower age bracket for *M. pneumoniae* (average age 38 ± 13 years) than for influenza (average age 54 ± 16 years). Serological evidence of an association of *M. pneumoniae* with myocarditis and pericarditis has been presented previously by Satz, et al.[9] This group also isolated *M. pneumoniae* from pericardial fluids and postmortem heart tissues. Our results also suggest that *M. pneumoniae* may be responsible for some cases of pericarditis and myocarditis.

M. Pneumoniae Outbreak

The outbreak involved a Puerto Rican family of seven children, one boy aged 8 years and six girls of ages 12, 11, 9, 5, 4, and 3 years. The family was directed to our attention on September 5 by the family physician who made a clinical diagnosis of pneumonia and prescribed therapy. The home, located in a poorer section of the community, was clean and well kept. The mother, age 31, was asymptomatic during this outbreak and only showed residual antibodies to *M. pneumoniae*. The index case was the oldest daughter, 12, who became ill on July 26, one week after returning from a two-week vacation in Puerto Rico with her mother. The boy developed symptoms two weeks later in mid-August and the remaining five children reportedly became ill during the first week in September. None of the family could recall any contact with an individual with serious respiratory symptoms either in Puerto Rico or Milwaukee.

All the children experienced a severe prolonged cough of two weeks duration, fever, chills, headache, and nausea; the boy and four-year-old girl also complained of severe chest pains. X-ray films of the boy and girls aged 11, 9, 4, and 3, taken on September 5, were

reported as negative except the one for the girl age 9. This film showed evidence of bronchiolitis in the 5th intercostal space and base. Paired serum samples were collected on the five children who were x-rayed but only convalescent samples on the other children. The convalescent serum specimens were drawn on September 21. Only the paired sera of the boy showed an increase in CF antibody titer compatible with an active infection of *M. pneumoniae*. The remaining four children had titers compatible with presumptive infections. Cold agglutinins also were present in either the acute or convalescent sera of all seven children.

Attempts at virus isolation were negative. However, a mycoplasma was isolated from the 8-year-old boy. The isolate produced "fried egg"-shaped colonies on PPLO agar. Since the isolate (1) was inhibited by methylene blue in agar, (2) did not ferment dextrose, (3) hydrolyzed arginine, (4) required yeast extract for growth, (5) hemadsorbed chicken red blood cells, and (6) did not hemolize sheep red blood cells, it was assumed to be *M. orale* type I or III. Because this organism can be isolated quite frequently from the oropharynx and had not been shown to be associated with clinical illness, its role in the family outbreak of pneumonia is doubtful. The fact that the throat washes were taken late in the illness when only one child, girl age 4, still had overt clinical symptoms, may account for the lack of isolation of *M. Pneumoniae*.

Discussion

Several interesting and unique features of *M. pneumoniae* infections were encountered in the family outbreak studied. Typically the outbreak was initiated with a single index case and followed by a secondary case approximately two weeks later. The subsequent simultaneous infection of the five remaining children, however, is unique and only a limited number of similar outbreaks has been reported. Of interest also was the fact that we were unable to find any evidence of respiratory infections at the school attended by these children, among the neighbors and among related children of similar age who lived upstairs and had daily contact with these children during the period of illness. Similar observations were noted by Evatt, et al[10] who reported that under special circumstances of intensive exposure, *M. pneumoniae* is capable of producing limited abrupt epidemics.

Only limited conclusions can be made of the role of *M. pneumoniae* infections in the community because of the small number of cases studied. The results clearly show, however, that we are encountering a significant number of confirmed cases, and that since 1966 *M. pneumoniae* has been diagnosed in 9 to 20 percent of the respiratory cases tested annually. It is important to note that of the *M. pneumoniae* infections confirmed in our study, the highest incidence occurred among patients in the age groups of 20 to 29 years and 10 to 19 years. The results of other investigators[2, 11] have established that the majority of *M. pneumoniae* infections occurs among people between the ages of 5 and 25 years and that the highest incidence of pneumonia occurs in the 6- to 19-year age group.

Our serological findings also appear to confirm reports received from physicians of a significant increase in clinical cases of atypical pneumonia from November through January. The data is insufficient to confirm the reported cyclic pattern of significant increases every four or five years but does indicate a significant increase of infections in 1968. Studies will be continued to determine if any cyclic pattern is prevalent in our area.

The incorporation of *M. pneumoniae* into our routine virus serology screening program has demonstrated a significant occurrence of this agent not only in suspected clinical syndromes but also in atypical syndromes. Particular interest is noted to its association with cardiopathies.

Finally, it is important to note that the work of other investigators has demonstrated a high degree of infectivity of this agent among members of families, with many cases being subclinical. Observations on the possible role of this agent in such subclinical and minor respiratory infections are worthy of further consideration.

ACKNOWLEDGMENT: The authors wish to acknowledge the technical assistance of Karen Radtke and Calvin Abel.

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Current Management of Acne Vulgaris

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ACNE VULGARIS is a disease of adolescence and is sufficiently common to be viewed almost as a normal physiologic increase in sebum from the pilosebaceous follicules. There appears to be a genetic predisposition with the onset occurring around puberty and as a rule with involution by the age of about twenty. The primary lesion is a comedo (blackhead) which is a combination of sebum and keratin dilating and filling the follicular orifice with later development of papules (grades I and II). Acne may be followed by subacute and chronic inflammation presenting as pustules or cysts which may cause scarring, (grades III and IV). The sites most commonly involved are the face, the upper dorsa of the trunk, and the chest. The skin is usually oily and there may be associated seborrhea of the scalp (dandruff). The treatment of acne is, of course, not only important for the cosmetic aspect, reducing eventual scar formation, but also for the social and psychological impact on the young patient. The management of acne includes both topical and systemic therapy.

Topical medications alone are usually sufficient in grades I and II but in addition antibiotics would also be needed for grades III and IV. The most recent and extremely useful topical medication is vitamin A acid or Retin A.

Topical Treatment

NEW VITAMIN A ACID: Vitamin A acid (Retin A) is available in three forms, a cream, tinfoil wrapped swabs soaked in vitamin A acid, and a 2-ounce bottle. Usually the swabs are useful to start and avoid excessive application. The patient should be instructed to apply that amount daily which will induce mild redness and peeling, usually on daily or alternate days, with maximum irritation occurring by the tenth to fourteenth day. Initially there is often intense itching within half an hour after application, but by the sixth week discomfort and erythema are usually minimal. Vitamin A acid may be applied in the morning or an hour or so before bedtime and the patient is instructed to keep washing of the skin to a minimum.

The author started more than 500 patients on this medication since it became available in Wisconsin early in 1972, and it is true that some patients have to be persuaded to continue application, but the results are unbelievably good. Disappearance of comedones and papules often occurs after three months, and continued application can then be on alternate days or twice weekly. The manufacturer stated that it was not effective when used in acne with severe pustules and deep cysts; i.e., acne conglobata. However, in our experience patients have completely cleared, apart from residual scarring using the topical vitamin A acid and, of course, with the administration of antibiotics. Washing the skin should be kept to a minimum during the early days of application of vitamin A acid using the mildest soaps. It is advisable to apply no other medication at the same time. Excessive exposure to sunlight should be avoided during the first four to six weeks after starting vitamin A and application.

The following topical medications may be selected as alternatives to vitamin A acid:

SOAPS: The author likes to use an abrasive cleansing soap once or twice daily. Usually these soaps contain particles such as polyethylene as well as sulfur (1-2%) and salicylic acid; for example, Brasivol which is available in fine, medium or rough particles, or Ionas and Pernox.

DRYING AGENTS: The purpose of the drying agent is to remove the shiny appearance of the oil and cause peeling or scaling which should be just visible but not too uncomfortable for the patient. Usually the medication is applied twice daily but

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overdrying can be avoided by reducing applications or selecting a weaker preparation. There are many commercial brands available but it is best to become familiar with a few of these preparations most of which contain resorcin (R), salicylic acid (Sa) and sulfur (Sf) in various strengths and combinations some of which are listed below:

*Sulfacet (Sf 5% and sodium sulfacetamide 10%)
*Acnomel (Sf 8% and R 2%)
Resulin (Sf 8% and R 2%)
Transact (Sf 2%)
*Acne-Dome Cream (Sf 8% and R 6%)
*Rezamid (Sf 5% and R 2%)
Pisec (Sf 2%)
Fostex Cream (Sf 2% and Sa 2%)
Komed (Sa 2%, R 2% and sodium thiosulfate 8%)
Acno (Sf 3%, Sa 2% and isopropanol 25%)
*Cort-Acne (Sf 5% and R 2%)
*Fosteril (Sf 2%)
Xerac (Sf 4%, isopropyl alcohol 44%)
*Available with coloring additives.

Cosmetic preparations are usually important to girls and women, and topical medications can be obtained with coloring additives in various blonde or brunette shades, such as found for example in preparations marked with an asterisk above. For boys or men, S.A.R. lotion which may contain your prescribed strengths of salicylic acid (0.5 to 2%) and resorcin (1 to 6%) in 70% isopropyl alcohol, can be suggested under the guise of an after-shave lotion. Benzoyl peroxide 5% (in vanoxide) or 10% as in Panoxyl are other useful peeling agents. Lotio alba often can be added to the program, particularly for application at night.

PEELING PASTE: Since the introduction of vitamin A acid, we have not had occasion to use a peeling paste. In the past the peeling paste would be applied for one to five minutes by the physician in the office and was particularly useful for the resistent or occasionally lax patient. Such a paste can be made up as follows in grams to a total of 487 gm: resorcin, 224 gm; zinc oxide, 56 gm; kaolin, 28 gm; peanut oil, 67 gm; and anhydrous wool fat, 56 gm, in petrolatum, 56 gm.

ULTRAVIOLET LIGHT: Acne tends to improve in the summer, and worsen in the fall and winter. Sunbathing should be encouraged, and in some instances artificial ultraviolet (UV) light source may be used such as a cold or hot quartz mercury lamp, gradually increasing the minimal erythema dose. There are a number of commercially available lamps such as Hanovia, and the smaller ones do as well, but a longer exposure time is required. It is advisable to remind the patient that halving the distance of the lamp to the skin will increase the light intensity by four times. The effect of ultraviolet light is somewhat similar to the drying agents.

X-RAY: This should be left to the expert and reserved for the selected few severe cases of cystic acne, the effect of which would be to decrease the size and activity of the affected sebaceous glands. As a rule, a maximum total of 800 R in ten divided doses at two- to three-week intervals can be used. Great care should be taken to shield the thyroid gland. The author would even go so far as to state that since the introduction of vitamin A acid, x-ray therapy hopefully should not be needed.

SHAMPOOS: Dandruff is often associated with acne and if the oily hair is worn across the forehead, acne is harder to control in this area. Shampooing with such medications as Sebulex (Sf 2% and Sa 2%) or Capsebon or Ionol (Sa 2%), Xseb (Sa 4%) two or three times weekly or Selsun (selenium disulfide) less frequently may be used.

Additional Therapy for Cystic Acne

Failure to relieve obstructed sebaceous glands may be associated with an overgrowth of mainly Staphylococcus albus and Corynebacterium acnes. These bacteria apparently act on the triglycerides in sebum to form free fatty acids, which is partly responsible for inflammation in the surrounding dermis.

ANTIBIOTICS: Reduction of inflammation and free fatty acid formation usually can be achieved by small amounts of antibiotics such as tetracycline, 250 mg two or three times daily, and, depending on the success of therapy, repeated at intervals or continued for several years. Demethylchlortetracycline (Declomycin®), 150 mg two or three times per day, is also useful but can cause photosensitivity, although less likely in these doses. The author's preference is for clindamycin hydrochloride (Cleocin®) for more serious cases, 150 mg once to three times daily. Although this is five times more expensive than tetracycline, less of the antibiotic is required. Side effects of tetracyclines and clindamycin may include gastritis or development of a thrush or monilial intertrigo, and although generally safe, the medication should be avoided during pregnancy.

ACNE SURGERY AND INTRALESIONAL CORTICOSTEROIDS: Removal of comedones with a comedone extractor and occasional release of cystic contents with a fine point of a blade are useful procedures; but since using vitamin A acid, the author has performed this less frequently. Injection of triamcinalone acetonide suspension, 10 mg/ml

diluted 2 to 4 parts with sterile physiologic saline, will cause considerable involution of persistent cystic lesions and is a useful addition to the program.

HOT WET PACKS: Vlem-Dome or Vleminckx's solution (NF), one teaspoonful to a pint of hot water, can be applied as a hot wet pack for 10 to 30 minutes once daily for a few days. The disagreeable smell of released sulfurated hydrogen warrants a well ventilated room or the back porch. Much the same effect for milder cases can be achieved with a nightly application of Sulpho-lac cream (modified Vleminckx's 57%).

General Management

DIET: The importance of diet is debatable. However, an increase in weight should be avoided; and if the patient gives a history of exacerbation after eating chocolate, nuts, or Coca-Cola, then these should be avoided.

DERMABRASION: Removal of scars by abrasion with a rotating diamond, wire brush, or sandpaper; or topical application of trichloracetic acid is now being viewed with less favor and should be left to the expert. The effect of tincture of time (5 to 10 years) is probably worth one dermabrasion; keloids and postinflammatory pigmentation may complicate the cosmetic result.

ESTROGENS: Testosterone causes increased sebum and exacerbation of acne, but estrogens cause some suppression. A number of patients receiving progestin-estrogen cyclic therapy for contraception have had improvement of acne but seems to be effective only during the first few months. Discontinuing the estrogens may lead to exacerbation of acne.

Summary

Some of the newer and traditional forms of therapy for acne have been described. If the author had to select one program for mild comedone and papular acne, it would be the topical application of vitamin A acid daily or alternate days; and if there is associated cystic acne, the addition of an antibiotic usually Cleocin, 150 mg once or twice daily. □

The Autopsy As An Investigative Tool

Edward A. Birge, MD, Milwaukee Wisconsin

OVER THE SPAN OF the last quarter century the autopsy has been steadily losing favor as an investigative method for the study of disease. Increasing emphasis has been placed upon newer, more sophisticated biochemical and physiological methods. Academic research workers, in particular, have largely discarded the autopsy in favor of other methods of investigation. Even in the general hospital the autopsy has become less popular and less commonly performed. This has been due to a combination of factors for which pathologists, clinicians, and hospital administrators must all share the blame. Quite recently the Joint Commission for Accreditation of Hospitals removed the last stimulus for performing autopsies by no longer requiring hospitals to maintain a minimal autopsy percentage.

This unfortunate turn of events has made the work of review committees, such as the Maternal Mortality Study Committee, increasingly difficult and exasperating. After discussing a maternal death, in an attempt to determine both the cause of death and the circumstances leading up to this unfortunate event, members of the committee often find themselves faced with questions which can only be answered if a properly conducted, sophisticated autopsy has been performed. This is particularly aggravating when death occurs suddenly and unexpectedly, particularly if it occurs immediately after delivery. Decisions and diagnoses based entirely upon the written clinical record, no matter how complete the record, must still be regarded as unverified guesses, the accuracy of which will vary depending upon the clinician's diagnostic acumen and the detail of his written record.

The Maternal Mortality Study Committee urges all physicians to strive to obtain autopsies on any maternal deaths that may occur in their practice, even when the cause of death appears to be obvious. The number and distribution of pathologists in the State of Wisconsin is now such that adequate pathology coverage is available everywhere. A properly performed autopsy will do a great deal to establish a definite diagnosis. Once a correct diagnosis has been established, the cause becomes of greater value for the attending physician, the obstetrical staff, and for the medical profession in general.

Doctor Birge is Pathology Consultant for the Maternal Mortality Study Committee, a subcommittee of the Division on Maternal and Child Welfare of the State Medical Society of Wisconsin.

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Edited by Gastone G. Celesia, MD, Vice-President

The Syndrome of Transient Global Amnesia

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Bender (1956, 1960) first described "a syndrome of isolated episode of confusion with amnesia" in 26 patients. Fisher and Adams (1958, 1964) independently reported 17 similar patients, named the condition "transient global amnesia" and gave an extensive discussion of possible etiologic factors. A number of subsequent reports have appeared in the literature.

The syndrome is characterized by the sudden onset of a severe deficit in short-term memory. There is relative preservation of immediate, long-term, and personal memory. Recovery is usually rapid and complete in a matter of hours with the exception of permanent amnesia for the attack. Neurologic abnormalities have been lacking in the few patients examined during the episode or following recovery. Recurrence is unusual. The etiology remains obscure.

Three additional cases were discussed in this paper collected in a two-year period from a small community hospital population. One case was examined repeatedly during the episode and an electroencephalogram was performed during the recovery phase. A discussion of memory mechanisms and possible etiologies was included. □

Acute Necrotizing Myelopathy Associated with Carcinoma of the Breast

Paul G. Gottschalk, MD, Marshfield

The occurrence of noninvasive acute necrotizing myelopathy in association with malignant tumor is rare. There are thirteen well documented cases in the world literature. Only one of these had carcinoma of the breast. The report of another such case was presented.

The patient, a 56-year-old white female, was admitted on July 14, 1969 because of intractable left upper extremity pain since May 1969 when an intra-arterial catheter was placed through the left brachial artery to the region of the thyrocervical trunk for infusion therapy of metastatic carcinoma of the breast involving the left side of the chest wall, supraclavicular and axillary nodes. The catheter was removed the day following admission.

On admission neurological examination revealed left ptosis and weakness and absent muscle stretch reflexes in the left upper extremity. There was a dense reduction in superficial sensation over the outer aspect of the left arm, forearm, and hand with a slight reduction over the remainder of the hand. Over the next 29 days the patient developed ascending weakness and sensory loss terminating in flaccid quadriparesis and death. Myelography showed no evidence of spinal cord compression. Postmortem examination revealed extensive necrotizing lesions involving the cervicothoracic spinal cord.

Possible underlying mechanisms were considered including: (a) autoimmune, (b) vascular, (c) viral, and (d) toxic. □

Normal Pressure Hydrocephalus Occurring with Basilar Impression Due to Paget's Disease of the Skull

Paul G. Gottschalk, MD, Marshfield

Basilar impression is frequently associated with Paget's disease of the skull. Various syndromes have been attributed to this condition, including cerebellar compression, obstruction of the fourth ventricle, spinal cord compression, secondary syringomyelia, and symptoms of vertebrobasilar insufficiency. Normal pressure hydrocephalus occurring with basilar impression has not been reported.

The case of a 65-year-old white female with basilar impression due to Paget's disease was presented. Her chief complaints included progressive ataxia of gait for three years and progressive deterioration of memory for one year. On examination there was frontal bossing, asymmetrical facies, bilateral hearing loss, moderate diffuse intellectual deficit, and a wide based, ataxic gait. Skull x-ray films revealed Paget's disease of the skull with platybasia and basilar impression. A pneumoencephalogram showed normal cerebrospinal fluid (CSF) pressure with dilated lateral and third ventricles. No air was visible over the brain convexity. A RISA cisternogram was highly suggestive of normal pressure hydrocephalus.

The etiology of normal pressure hydrocephalus in this case was thought to have been due to mechanical obstruction of the basilar cisterns as a result of the basilar invagination. Because of the potential treatability of normal pressure hydrocephalus, this syndrome should be considered in patients with Paget's disease of the skull who have dementia or gait disturbance. □

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- promptly relieves hyperacidity
- also relieves fullness and bloating
- non-constipating

LIQUID **MYLANTA**® TABLETS

aluminum and magnesium hydroxides with simethicone

STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthīne is provided in several different dosage forms and combinations which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthīne® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Sustained" action—Pro-Banthīne P.A.® (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized.

High-level anticholinergic activity is maintained all day and all night in most patients with only two tablets every eight hours.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

A "diagnostic tool"—Pro-Banthīne may be used parenterally to immobilize the duodenum for more revealing roentgenographic appraisal through hypotonic duodenography.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Vigorous anticholinergic action — Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5-mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthīne P.A.—Each tablet of Pro-Banthīne P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

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Medical Department, Box 5110, Chicago, Ill. 60680

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Pro-Banthīne®

brand of
propantheline bromide

a good option in peptic ulcer

Placidyl®
(ETHCHLORVYNOL)

Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

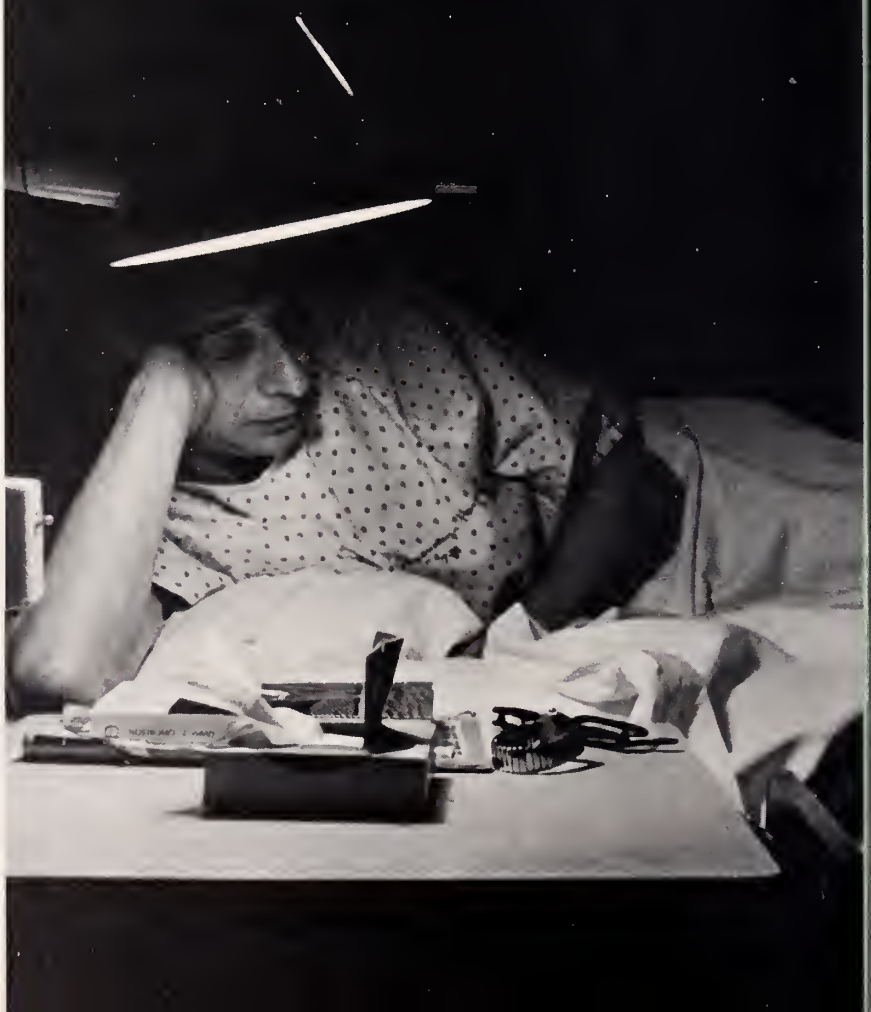
When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl® CIV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)



STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, No. 9 SEPTEMBER 1973

FROM THE PRESIDENT

You'll Like It!

APPEARING ON THIS PAGE is a letter I recently sent to all Wisconsin legislators inviting them to spend time with a physician in his daily practice setting. We have gone to legislators with our positions many, many times recently. Now, I am offering them the opportunity to come to us with their questions and thoughts. This will let them see where the action is in the care of patients.

We all know what busy schedules and lives both physicians and legislators lead. We also know the many different types of decisions and actions we must take every day. However, legislators should be given the opportunity first hand to communicate with you just as you have the opportunity to communicate with them.

For the sake of your patients and freedom to practice medicine in the interest of those patients, won't you please take the opportunity to spend part of your day in your office and at the hospital with your elected representative?

Let your legislators see the system in action. Try it, I think you'll like it!

THE STATE MEDICAL SOCIETY OF WISCONSIN
330 EAST LAKESIDE STREET • P. O BOX 1109 • MADISON, WISCONSIN 53701 • 608 257-6781

September 14, 1973

TO: Members of the Wisconsin Senate and Assembly

Dear Friends:

Now that both Houses of the Legislature are in recess and you are back in home territory, I would like to suggest that it might be valuable for you to spend part of a day with a physician in your area. As you know, health care has been, and undoubtedly will continue to be, the subject of many bills, much debate and a lot of interest during this session. As President of the State Medical Society, I have contacted you during the past few months as have other physicians and representatives of medicine. The Society, as you know, has also invited physicians to come to Madison to spend a day in the Capitol so that they would have a chance to see how the Legislature works and to see the many complex issues and problems facing you as a representative of your constituents.

It is my feeling that perhaps the best way to provide you with a chance to find out first-hand why we take many of the legislative positions we do is to suggest that you take time from your busy schedule to spend time with a physician. This will let you ask questions and find out what goes on in a daily medical practice setting that shapes your doctor's thinking on legislative proposals.

Programs to provide Wisconsin with more doctors, attempts to pass physicians' assistants enabling legislation, and many other bills have received the support of the State Medical Society. We also have opposed proposals which we feel would increase the physician shortage, would place unnecessary controls on the practice of medicine, and would interfere with the relationship between the patient and the physician.

So, I urge you to give a physician of your choice a call and ask him to make himself available to you in his ordinary daily work setting. If it would be easier for you, I would be happy to set up such an appointment and arrange a mutually convenient time for both you and the doctor.

In any event, I not only want to offer the services of the Society in this way but also want to let you know that it stands ready to be of assistance to you in matters affecting the health of Wisconsin's citizens. We thank you for the interest you have shown during this session and hope that you will continue the interest in health-care legislation expressed by many of our representatives to date.

Sincerely,

D. J. Dorius M.D.

President

Getting It Together on Health

THOSE TRAUMATIC teenage years will be the subject of the State Medical Society's 1973 Wisconsin Work Week of Health October 2, 3 and 4. The theme is "Getting It Together on Health."

The program is open to the public and is designed to help both the teenagers themselves and those who deal with their problems. Speakers from across the country will make up the three-day free program which will include many chances for teenagers and adults to discuss what they have heard with the speakers, expert discussion leaders, and each other.

Program planning was done with the help of Wisconsin teenagers contacted by the Woman's Auxiliary to the State Medical Society. Also kept in mind were the needs of high school health educators who often need additional background information to help them teach effectively.

Some 30 speakers and discussion leaders will be on tap for the Tuesday, Wednesday, and Thursday sessions. All three days of programs will be held at State Medical Society headquarters, 330 East Lakeside Street, Madison.

On October 2 the general topic will be "Love is Not Having to Say You're Sorry" and the program will lead off with psychiatrist Seymour Halleck, MD. His focus will be the teenage years as they fit into an individual's development from cradle to maturity.

A common teenage question, "Am I Normal?", will be dealt with by Judy Jones of Milwaukee Planned Parenthood. Where values fit into what could be called "love education" will be discussed by James Merrill, executive director of Lutheran Social Services of North Dakota.

The day will be opened by Barbara Thompson, PhD, state superintendent of schools. The state Department of Public Instruction is cooperating in program planning.

Moderator for the day will be Effie Ellis, MD, of the American Medical Association who has long worked with programs across the country for teenagers.

On October 3 "Getting Your Head Together" will be the theme. Alternatives to drugs will be discussed by U.S. Public Health Service physician V. Alton Dohner, MS, MD. Also scheduled are: Jerome Witherill of the University of Wisconsin, Whitewater, on values and decision-making; John Stephenson, MD, Madison, director of the new University of Wisconsin Teenage Clinic on "What to Do Before the Psychiatrist Comes;" and Robert Kaplan, PhD, Ohio State University health educator, on "With a Little Help from Our Friends . . . the Adults!" Moderator will be Darold Treffert, MD, Fond du Lac, superintendent of Winnebago State Hospital.

On October 4 the topic will be "Who are You?" An introduction to human effectiveness training will be given by Wayne Allan of Effectiveness Training Associates, Denver, Colorado. Other topics will be: "Red, White and Blue Genes" by James Crow, MD, Madison, University of Wisconsin geneticist; "Adolescence as a Learning Experience" by Robert Anderson, MD, child psychiatrist at the University of Wisconsin Teenage Clinic; and "Parents are People" by Catharine Richards, PhD, chief of youth services with the U.S. Department of Health, Education, and Welfare, Washington. Moderator will be Stanely Graven, MD, University of Wisconsin professor of pediatrics.

This is the 11th annual Work Week, believed to be the only program of its kind in the nation. There is no registration fee. However, the Medical Society requests pre-registration. Information is available from the Society headquarters, 330 East Lakeside Street, Madison. □

SEYMOUR HALLECK, MD

Keynote Speaker

Keynote speaker for "Getting It Together On Health," will be Seymour Halleck, MD, nationally known psychiatrist formerly on the University of Wisconsin faculty and now at the University of North Carolina, Chapel Hill.

Dr. Halleck has long been outspoken on social problems in a number of areas. These have included drug education, women's liberation, "living together," suicide, mental commitments, the effect of the youth-sex revolution on women over 35, sports, and what killed the New Left.

His articles for scholarly journals have included studies of student dissent, the draft, delinquency, crime, sexual behavior, drugs, and community psychiatry.

On October 2 he will be talking about adolescence as part of the continuum of development that begins at birth and goes through old age, particularly the sexual aspects of that development.

Late News!

UW Med School Dean Named

Lawrence G. Crowley, MD, associate dean of the Stanford University School of Medicine, has been appointed dean of the University of Wisconsin Medical School, Madison. □

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

EFFIE ELLIS, MD

Expert Assistance

Planning this year's Wisconsin Work Week of Health was done with some expert assistance. When members of the Woman's Auxiliary and the State Medical Society staff sat down to work on the program, they were joined by Effie Ellis, MD, the American Medical Association staff member who was deeply involved in planning the Quality of Life Congresses the AMA held starting last year.

Dr. Ellis is a pediatrician and she has brought to her job as the AMA's Special Assistant for Health Services a special concern for children and what they need. Her philosophy is "there's nothing in this country as valuable as our children."

She feels there is not enough concern about "human ecology, the relationship of the individual to the environment. Attention is paid to the environment, but far too little is paid to the individual's environment."

It was with this in mind that she directed the planning of the 1973 Wisconsin Work Week of Health to the environment that surrounds the adolescent. In addition to helping with that planning, she will serve as moderator for the first day's program.

Dr. Ellis has been with the AMA since February 1970. Before that she was director of maternal and child health for the Ohio Department of Health for 10 years. She came to Ohio from a post as Director of Medical Education at Provident Hospital in downtown Baltimore, Md., where she had worked extensively with the poor.

GOVERNMENT

The Awakening Begins

When Congress passed the 1972 Social Security amendments last fall, physicians as a whole were not much more aware of many of the changes than anyone else. The awakening has begun.

The initial jolt was PSRO, the Professional Standards Review Organization. This part of the law requires routine quality checks of health care paid for with Social Security funds. This includes review of the kind of treatment and the drugs and other services physicians provide or prescribe to make sure they are medically necessary and meet government standards, or norms, of care. The agency to do this checking will be a PSRO.

Less widely publicized than PSRO but likely to have more immediate effect on a physician's practice are two other parts of the 1972 Social Security amendments. These sections of the law went into effect July 1.

They require physicians to take three extra steps for each of their Medicaid patients who are hospitalized, admitted to skilled nursing facilities, intermediate care facilities, or mental institutions.

ONE. The attending physician must certify the need for inpatient care. This is required when any Medicaid patient is admitted to an institution or if an inpatient applies for Medicaid.

No later than 60 days after admission, the physician is asked to recertify the need for continued inpatient care (90 days for patients in mental institutions) with continuous recertifications at these intervals. At the time of each recertifi-

continued next page

PHYSICIAN CERTIFICATION and RECERTIFICATION
(Health Care Facility)

CERTIFICATION (initial) of patient admission. Required at time of admission.

_____ (Patient) _____ (Health Ins. Claim Number)

_____ (Admission Date)

I certify that in-patient services are required to be given because of the above-named patient's need for medical and nursing services on a continuing basis.

_____ (Physician) _____ (Time & Date)

RECERTIFICATION of continued in-patient care. On or before the 60th day.

Date_____

I certify that continued in-patient care is necessary for the following reason(s):

_____

_____

_____

I estimate that the additional period of in-patient care will be_____ days (or_____weeks).
Plans for post in-patient care are: ☐ Home Health Agency ☐ Office Care ☐ Other(specify)_____

_____ (Physician) _____ (Date)

2nd RECERTIFICATION On or before the 120th day of in-patient care.

Date_____

I certify that continued in-patient care is necessary for the following reason(s):

_____

_____

_____

I estimate that the additional period of in-patient care will be_____ days (or_____weeks).
Plans for post in-patient care are: ☐ Home Health Agency ☐ Office Care ☐ Other(specify)_____

_____ (Physician) _____ (Date)

3rd RECERTIFICATION On or before the 180th day of in-patient care.

Date_____

I certify that continued in-patient care is necessary for the following reason(s):

_____

_____

_____

I estimate that the additional period of in-patient care will be_____ days (or_____weeks).
Plans for post in-patient care are: ☐ Home Health Agency ☐ Office Care ☐ Other(specify)_____

_____ (Physician) _____ (Date)

Instructions:
If this form is sent to the Physician by mail, a copy should be retained in the patient's record in the event the original is lost or misplaced.

Choosing the Top Society Officers

Who chooses the State Medical Society's candidates for top office?

Until now, the process has been done during the Annual Meeting by the Committee on Nominations.

In an effort to involve more Society members in the process, the procedure for nominations was changed by the House of Delegates at the last Annual Meeting.

On the morning of November 3, a Saturday, for the first time the Committee on Nominations will convene in advance of the Annual Meeting to hear suggestions for next year's officers. The meeting, at the State Medical Society's headquarters in Madison, coincides with the fall meeting of the Council.

Every member of the State Medical Society is invited to come and express his views, make suggestions in advance to his councilor district representative on the committee or address a letter to the committee at State Medical Society headquarters.

This year nominations are in order for the following offices:

President-elect (now J. E. Dettman, MD, Green Bay)

Vice-speaker (now Patricia Stuff, MD, Bonduel)

AMA delegates for seats now held by: J. M. Bell, MD, Marinette; G. E. Collentine, Jr., MD, Milwaukee; and C. J. Picard, MD, Superior.

AMA alternate delegates for seats now held by: E. M. Dessloch, MD, Prairie du Chien; D. J. Carlson, MD, Milwaukee; and H. J. Kief, MD, Fond du Lac.

The candidates chosen at this meeting will be publicized in the February issue of the *Wisconsin Medical Journal*. Additional nominations can then be made at the March 26 meeting of the House of Delegates, in Milwaukee, before the delegates vote on the new officers.

Members of the Committee on Nominations were elected at the last session of the House of Delegates in March during the Society's 1973 Annual Meeting in Milwaukee. There is one representative from each of the 13 Councilor districts of the State Medical Society and one representative of all of the Society's scientific sections.

They are Doctors: (Councilor District appears in parentheses)

John D. Riesch, Menomonee Falls (1st)
Raymond G. Welsch, Kenosha (2nd)
James N. Moore, Madison (3rd)
James J. Tydrich, Richland Center (4th)
Robert M. Senty, Sheboygan (5th)
James G. Bergwall, Hortonville (6th)
James T. Murphy, La Crosse (7th)
Kenneth L. Strebe, Oconto Falls (8th)
John B. Wyman, Marshfield (9th)
L. O. Simenstad, Osceola (10th)
Charles J. Picard, Superior (11th)
Chesley P. Erwin, Milwaukee (12th)
Theodore C. Fox, Antigo (13th)
Joel E. Taxman, Milwaukee (Scientific Sections) □

Awakening Begins

continued

cation. the physician is requested to indicate what care is planned for the patient after he is discharged from the facility.

TWO. The attending physician must have a written plan of care for each Medicaid inpatient he treats. (This requirement does not apply to general hospital admissions.) A form for this purpose is being developed. Pertinent items may include current diagnoses, recent laboratory findings, medical conditions, any abnormalities discovered by a physical examination and any feasible alternative settings for the patient's care. The completed-plan-of-care form becomes a part of the patient's clinical record.

THREE. Now Medicaid patients must be included in the utilization review plans, set up for Medicare patients.

A lack of satisfactory compliance with these three steps can lead to a reduction of the federal portion of Medicaid moneys paid in support of the patients involved.

The bureaucratic wheels should begin turning shortly to implement this new federal requirement. The State of Wisconsin sent its notice of these new requirements to institutions in August. □

EDGAR LIEN

Legislative Director

Edgar Lien, a former Chippewa County Assemblyman, has been named director of governmental affairs for the State Medical Society. He took the post August 1.

Mr. Lien will direct the Society's legislative activities and be its registered representative in the Legislature. Consulting legal counsel retained by the Society will continue to provide assistance on bill drafting and analysis.

Mr. Lien obtained his law degree from Valparaiso University in 1960. He practiced law in Bloomer, Wisconsin, from 1961 through 1965. From 1963 to 1965 he was the state Assemblyman from Chippewa County.

Since that time he has been a caucus analyst for the state Assembly, manager of the government affairs division of the Metropolitan Milwaukee Association of Commerce, and for the last six years was executive vice president of the Wisconsin Merchants Federation, Madison. □

COUNTY SOCIETIES

Family Planning

Each county medical society is urged by the State Medical Society's Division on Maternal and Child Welfare to devote one of its meetings to family planning. There are a number of physicians who can assist in presenting such programs if the county society does not have resources. At the Division's meeting August 10, Richard C. Brown, MD, Eau Claire, indicated his willingness to help out in such a case. □

WPS®

report

for Wisconsin Physicians

Volume 1, Number 5 September 1973

Clinic Services Operational in Wisconsin

Wisconsin Physicians Service, a leader in the health insurance field for many years and a company known for its work with the medical community, is now in a position to offer its expertise in the Electronic Data Processing field.

WPS is operating one of the most complete and thoroughly automated medical statement and insurance Billing systems offered in the State of Wisconsin in an effort to provide a key to many of the complex record problems facing the health care delivery system.

Clinic managers from throughout the state visited WPS Blue Shield home offices in August to see the new Clinic Services system first hand. Michael O'Leary, right, who is manager of the new service answered questions as he led a tour through the East Madison Clinic where the system is already in operation. Clinic Managers pictured from the left are: Richard Matthews, Medical Associates, Baraboo; Gary Stebnitz, Monona Grove Clinic; Roland Ebert, Richland Medical Center, Richland Center; and O'Leary.

A California system was adapted for use in Wisconsin and our first installation has been operating since April. This system automatically handles your patient record, statement calculation, insurance form processing and many other tiresome paperwork tasks necessary for proper maintenance of patient files. We support our system with an IBM 370 computer, peripheral equipment and more than 70 high-level computer programs. The system includes 11 different forms which help each clinic utilize the full capabilities of the system.

Clinic managers from throughout the state visited WPS home offices in August to view the new system first hand. They also toured the East Madison Clinic where the system is operational. Several more are considering installation.

ATTENDING PHYSICIANS REPORT

At WPS Blue Shield we do work to keep paperwork at a minimum. However, some paperwork from you is still necessary and we do appreciate the amount of your valuable time you spend on WPS forms.

An ongoing need is the medical information you supply about your patients who are applying for WPS Blue Shield health insurance. Completion of the WPS report is a service to your patient so he may obtain health insurance for himself and his family. If completing the WPS Attending Physicians Report is not convenient, a narrative or photo copy of your medical records is also acceptable.

and their *Medical Assistants*

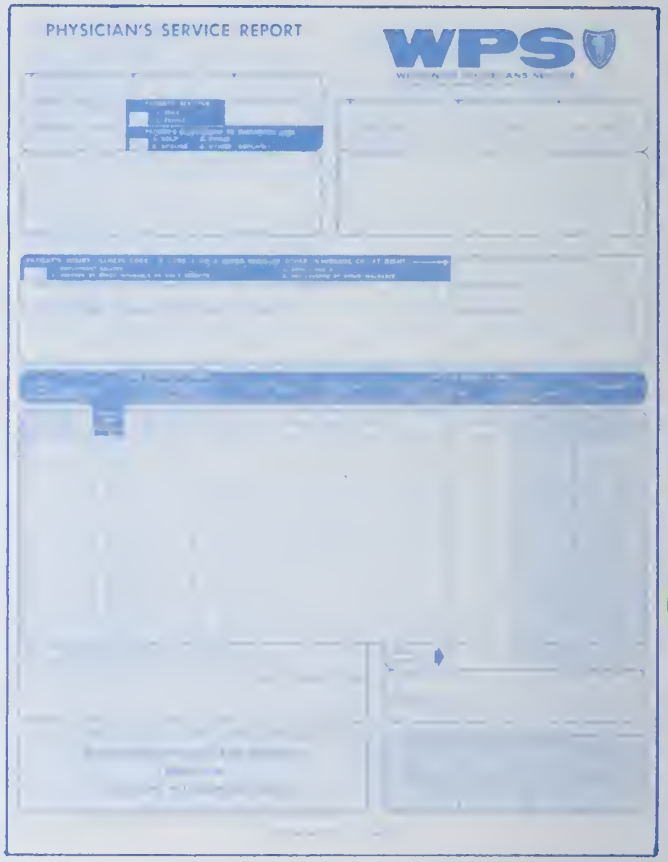
TIPS for Medical Assistants

In our July issue we introduced you to the new Physician Service Report. After reviewing claims submitted on the new reporting form, we would like to make the following comments:

1. Be sure to accurately code *Patient's Sex* and *Patient's Relationship to Subscriber*.
2. Please be accurate regarding the indicated *Place of Service* code and *Type of Service* code. We have noted certain inconsistencies; for example, '3. Inpatient' is often used when in actuality the service was performed in the outpatient department of the hospital or '5. Outpatient.'
3. If you use *Procedure* and *Diagnosis* codes, use the 1964 California Relative Value Guide for procedures and HICDA codes for diagnosis. Errors in coding can jeopardize the accuracy of the WPS payment.
4. Please differentiate between your charge for first day care versus follow-up in-hospital medical care in *Description of Service*. For example, if your first day care is $25 and follow-up care is $6 per day for ten days, then show:

first day care	$25
ten days follow-up	$60

Again we cannot emphasize the importance for the accuracy of the information contained on the claim reports. Accurately completed claim reports lead to prompt payments!



"Show This Card and Concentrate On Getting Well"

Front

Back

This identification card indicates that you are protected by WPS Blue Shield. Present it to your physician or to the hospital whenever you request health services.

This I.D. card shows your subscriber number and file number. To help speed up your claim payment, be sure to indicate these numbers on all claims and other correspondence. For information or assistance, contact your local WPS Regional Office.

Madison	Eau Claire
Kenosha	Milwaukee
Green Bay	Wausau

WPS®

WISCONSIN PHYSICIANS SERVICE

Box 1109 330 East Lakeside Street Madison Wisconsin 53701

The Blue Shield Plan of the State Medical Society

You'll be seeing more of this new WPS I.D. Card. Contemporary and styled for "easy-to-spot" use, the card will be in use by WPS Blue Shield subscribers this fall. Since you and WPS Blue Shield do most all the paperwork, this is the patient's ticket to concentrating on getting well.

WPS WISCONSIN PHYSICIANS SERVICE

Colic? Diarrhea? Eczema? Asthma? Rhinorrhea? Fretfulness? Fitful Sleep?

Soyalac is often the answer.

This ailing, wailing syndrome in infants (and older children) is all too familiar. Fortunately, the physician has at his command a trusted ally: milk-free, fibre-free, hypo-allergenic Soyalac.

Soyalac is palatable, readily digested and assimilated. It simulates human milk in appearance, taste, texture. It is complete with vitamins and minerals. It is equally suitable for children and adults allergic to cow's milk.

Through the years Soyalac has proved its value —in promoting growth and development—as attested by extensive clinical data.

Free samples and literature on request.
A simple note on your prescription form will do.

Now available in 3 forms:
Concentrated Liquid,
Ready-to-Serve, Powdered

Soyalac

a product of
LOMA LINDA FOODS
MEDICAL PRODUCTS DIVISION
RIVERSIDE, CALIFORNIA 92505
Mount Vernon, Ohio 43050, U.S.A.

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseling,

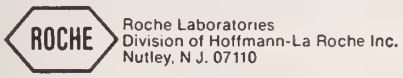
and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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(diazepam)

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INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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NEWS HIGHLIGHTS

New Appointments at Marshfield Clinic

The Marshfield Clinic Board of Directors August 14 elected three new members to its board and appointed an Interim Director of Medical Education. Elected to the Board were: Edwin W. Hoeper, MD, pyschiatrist; Gary F. Gilbertson, MD,* surgeon; and Stephen F. Wagner, MD,* pediatrician. Appointed Interim Director of Medical Education was Donald T. Fullerton, MD, psychiatrist. All of the physicians are from Marshfield.

In his new position as Interim Director of Medical Education, Doctor Fullerton will be responsible for the development and direction of new medical education programs at the Clinic, Marshfield Clinic Foundation for Medical Research and Education and St. Joseph's Hospital, Marshfield.

Nurses Group to Meet in Madison

The Wisconsin Nurses Association (WNA) will hold its convention outside the Milwaukee area for the first time in many years. Setting for the meeting October 10-12 is the Sheraton Inn-Madison.

Convention theme is "Quality Assurance: Rights and Responsibilities."

Speakers will include:

Edmund Pellegrino, MD, director of the health sciences center.

Winnebago Society Meets with Legislators

Members of the Winnebago County Medical Society in June met with Winnebago County's three members of the State Legislature at Hotel Menasha. From left are: Richard Roberts, MD,* Oshkosh, secretary of the Winnebago Society; Gordon Bradley, Omro, 57th district representative; Richard Flintrop, Oshkosh, 56th district; Howard Mauthe, MD,* Fond du Lac, councilor of the State Medical Society; and Michael Ellis, Neenah, 55th district. (Photo courtesy NEENAH-MENASHA DAILY NORTHWESTERN)

PHYSICIAN BRIEFS

Erwin O. Hirsch, MD*

. . . associate dean of the Medical College of Wisconsin, Milwaukee, has been assigned responsibilities for concentrating on continuing education programs of the College for practitioners throughout the state. Prior to joining the Medical College in October 1970, Doctor Hirsch was active in continuing education programs in New Jersey and at the national level. He earned his MD degree from Harvard University in 1946.

George H. Handy, MD*

. . . state health officer, Madison, has been appointed to a two-year-term on the Venereal Disease Control Advisory Committee of the National Center for Disease Control, Atlanta, Ga.

David T. Quanbeck, MD*

. . . Watertown urologist and a chapter president of the Kidney Foundation of Wisconsin, in August announced that the Watertown Department of Public Health in cooperation with the Foundation would be screening all public school five-year-old girls entering kindergarten with urine tests for bacterial infections. He indicated that this special screening has never before been done in Wisconsin. He acknowledged that special encouragement and preparation for having this program were provided by two staff members of the Veterans Administration Hospital in Madison: Calvin M. Kunin, MD, chief of medical service and professor of medicine, University of Wisconsin, and Jane DeGroot, RN, epidemiologist nurse.

Gunnar A. Gundersen, MD*

. . . La Crosse, chairman of the department of nuclear medicine, Gundersen Clinic, Ltd., recently was certified by the American Board of Nuclear Medicine, Inc. He also is certified by the American Board of Radiology. He joined the medical staff of the Clinic in 1956.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

State University of New York at Stony Brook. "The Question of Quality."

Sister M. Thomas Moore, OSF, department of social science, Silver Lake College, Manitowoc, "Organization Man: A Study in Rigor Mortis."

Sister Brigid Condon, formerly of Marycrest College, Davenport, Iowa, "Maintaining Quality of Patient Care Through Creativity."

Dr. Eileen Jacobi, executive administrator of the American Nurses Association, Kansas City, Mo., "Perspectives in Care."

The WNA Ad Hoc Committee on Quality Assurance will present "Quality Assurance in Health" at a general session, and a forum will be conducted by the organizations legislative committee.

An open forum will deal with "Continuing Education for Quality Assurance—Where Do We Stand?"

Conference groups in geriatric, maternal and child health, medical-surgical, and psychiatric nursing will meet concurrently on Thursday from 9 to 10:15 a.m.

Judith A. Johnson, Madison, is chairman of the WNA Committee on Program.

More information on program and convention fees can be obtained by writing the Wisconsin Nurses Association at 161 W. Wisconsin Ave., Room 6012, Milwaukee, Wis. 53203.

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Warren B. Rudy, MD*

. . . pediatrician at the Stahmer Clinic, Wausau, recently was elected president of the medical staff of Wausau Hospitals, Inc. Other new officers are MDs A. J. Molinaro,* vice-president, and W. C. Miller*, secretary.

Charles V. Ihle, MD*

. . . Eau Claire, recently became associated with the staff of the Ihle Orthopedic Clinic in Eau Claire. Doctor Ihle graduated from the University of Wisconsin Medical School and served his internship in San Francisco. After internship, he returned to the University of Wisconsin Medical School to complete a residency in orthopedic surgery. Prior to joining the clinic, he served in the United States Navy. Doctor Ihle is a diplomate of the American Board of Orthopedic Surgery.

Edward S. Scanlon, MD

. . . Menasha, recently became associated with the staff of the Riverside Clinic. Doctor Scanlon graduated from the University of Illinois Medical School in Chicago and served his internship at the Medical College of Virginia. He received his cardiology training at the Medical College of Virginia and the Mayo Graduate School of Medicine in Rochester. Doctor Scanlon also has held research positions with the Chicago Board of Health and Abbott Laboratories.

Uriel J. Limjoco, MD*

. . . Menomonee Falls, recently was elected president of the American Cancer Society, Waukesha Unit.

Andrew E. Cyrus, Jr., MD*

. . . Adell, clinical professor of the Medical College of Wisconsin for 16 years, recently accepted, the position as director of laboratories and chief pathologist for St. Nicholas Hospital, Sheboygan. Doctor Cyrus, a graduate of the Meharry Medical College, is the only neuropathologist in Wisconsin and one of only several in the nation. In 1967, he was named the outstanding clinical professor of the year, and the Dale Carnegie Institute also recently presented him with the Good Human Relations Award. Doctor Cyrus is president of the Multiple Sclerosis Society of Milwaukee.

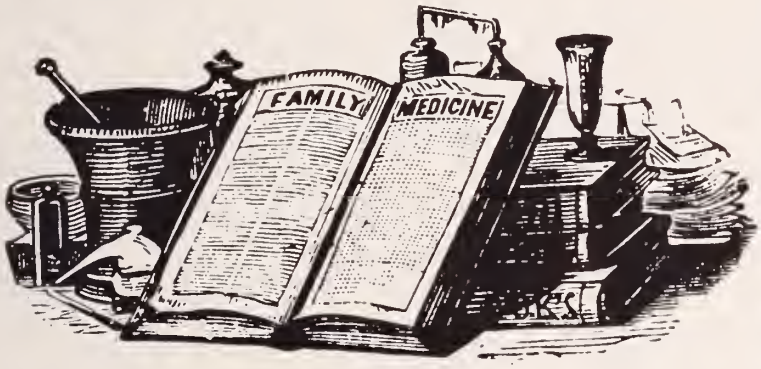
NEWS HIGHLIGHTS . . .

Mayo Clinic Orthopod to Speak in Madison

Lowell F. Peterson, MD of the Mayo Clinic, Rochester, Minn., will be the guest speaker at the fall meeting of the Wisconsin Orthopedic Society Friday, Oct. 9, at the Edgewater Hotel in Madison. His presentation will be "Total Knees." Advance reservations may be made with Paul W. Phillips, MD,* 212 S. 11th St., La Crosse, Wis. 54601.

Outagamie Society Elects Officers

At the May 17 meeting of the Outagamie County Medical Society the following physicians were elected to office: Thomas A. Ryan, MD,* Appleton—president; Eugene Raney, MD,* Appleton—vice-president; and J. T. Querol, MD,* Appleton, secretary-treasurer. □



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PHYSICIAN BRIEFS . . .

Kermit L. Newcomer, MD*

. . . La Crosse, internal medicine and kidney specialist at the Gundersen Clinic, Ltd. and Lutheran Hospital, recently was awarded the institutions' "Outstanding Teacher Award" for 1972-73. A 1959 graduate from Western Reserve University, Cleveland, he interned and served his residency at Walter Reed General Hospital, Washington, D.C. Doctor Newcomer joined the clinic-hospital staff in 1967.

William E. Hein, MD*

. . . of the Monroe Clinic, recently was installed as president of the Wisconsin Academy of Family Physicians. Robert F. Purtell, Jr., MD,* Milwaukee, was named secretary-treasurer, and MDs Donald J. Heyrman,* Menomonee Falls, and Theodore C. Fox,* Antigo, were named speaker of the Congress of Delegates and vice-speaker, respectively. Leonard B. Torkelson, MD,* Baldwin, was elected president-elect and will take office as president in June 1974.

John C. Manley, MD*

. . . Milwaukee, assistant clinical professor of medicine at the Medical College of Wisconsin and chief of the Cardiology Department, St. Luke's Hospital, recently was named president-elect of the Wisconsin Heart Association. He will assume the post of president at the 1974 meeting.

James Barrett, MD

. . . Janesville, recently joined the staff of the Janesville Riverview Clinic, Ltd. Doctor Barrett graduated from the University of Cincinnati School of Medicine and served a rotating internship at Los Angeles County General Hospital. After completing two years in the United States Air Force, he returned to the University of Minnesota where he completed a three-year residency in dermatology.

Hania W. Ris, MD

. . . Madison pediatrician and director of the Wisconsin School for Girls at Oregon as well as a clinical instructor at the University of Wisconsin Medical School, on August 10 presented a paper entitled, "Gonorrhea and the Pediatrician—Focal and Systemic Manifestations," at the University of Watwatersrand, Department of Pediatrics, in South Africa.

Your Finger Holds an Inflation Hedge

By ANNE TAYLOR

Money Matters

If you purchased a medium quality, one-carat diamond ring just 10 years ago, you probably paid about $850 to $900 for it. You or your spouse to be, that is.

Prices are changing rapidly today, but the chances are that if you priced your diamond now you would find the market value closer to $2,000, perhaps even more.

This does not necessarily mean you will obtain that price. If you sold your diamond to a retailer, he would probably give you a lower wholesale price so as to obtain a profit on the resale. But it still would be a lot more than you paid for it.

IF YOUR diamond was of high quality, your purchase price 10 years ago would have been close to $1,600. If you got it for much less than that—and selling prices very—you would have had a bargain.

That bargain has compounded itself since then, because as I read the statistics before me, gathered by Dun & Bradstreet, I find that high quality, one-carat stones were selling for $3,800 in February.

SINCE THEN, however, there have been at least two price increases, and that some item now has a market value of about $5,000.

I find these statistics distressing, to a degree, because they suggest that inflation is everywhere you look. This year's brides, therefore, might have to accept smaller stones or some of the low priced simulations.

But I find a brighter facet also—the fact that more than 20 million American women wear diamonds on their fingers. For them, the diamond's beauty glistens even more because of inflation.

WELL, YOU say, other than making me feel that I am beating this inflation, other than making me feel a bit better off, other than making me feel I am under-insured, what good comes to me from rising diamond prices?

All of the foregoing observations have merit. It is true that very few people actively contemplate selling their diamonds; they are considered family treasures, to be held for generation after generation.

I CONCEDE this to be so. But real benefits do accrue to you, especially in extreme emergencies. Let us hope that you escape them, but those who have been down to their last dime appreciate that a diamond is like money in the bank.

From WISCONSIN STATE JOURNAL, Sunday, July 29, 1973

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PHYSICIAN BRIEFS . . .

Michael Bachhuber, MD*

. . . Mayville, recently was promoted to the position of chief pediatric resident at Milwaukee Children's Hospital. Doctor Bachhuber graduated from Marquette School of Medicine (now the Medical College of Wisconsin) and interned at St. Francis Hospital, Peoria, Ill. Prior to taking a pediatric residency, Doctor Bachhuber had been associated with his father, the late Francis Bachhuber, MD of Mayville.

Ghulam Mohammad, MD

. . . Sheboygan, recently joined the staff of the Sheboygan Clinic as a pediatrician. He graduated from Dow Medical College, Karachi, Pakistan, and served his internship at St. John's Queens Hospital, New York City. His residency was taken at St. Catherine Hospital, New York Medical College-Metropolitan Hospital Center, and Brooklyn-Cumberland Medical Center, New York. Prior to joining the Sheboygan Clinic, Doctor Mohammad completed a two-year fellowship in pediatric hematology at Milwaukee Children's Hospital. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1973

7 Clinic Services Seminar
9 Joint Committee on Drug Formulary
10 Maternal Mortality Study Committee and SMS Division on Maternal and Child Welfare
14 In-Depth Program Planning Committee
16 State Woman's Auxiliary Health Education Committee
16 Ad Hoc Committee and Executive Committee of SMS Commission on Medical Care Plans
28 Legislative Committee of In-Home Services Task Force
30 SMS Commission on Health Information
30 Board of Directors, Wisconsin Health Care Review, Inc.

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

SECTION OPHTHALMOLOGY

SEPTEMBER 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EXECUTIVE AND LEGISLATIVE MEETING

The Section's legislative and executive committees met July 25 to discuss the petition by five optometrists to the Wisconsin Optometry Examining Board that a rule be enacted by the Wisconsin Optometry Examining Board approving use of appropriate diagnostic pharmaceutical agents by optometrists.

The meeting was called by Elmer Johnson, MD, Madison, chairman. Present were: MDs James C. Allen, Madison; Samuel Blankstein, Robert Hynduick, and Herbert Giller, Milwaukee; James V. Bolger, Waukesha; and Dwain Mings, Monroe. Also present were H. B. Maroney, assistant secretary of the State Medical Society, and Pharis Horton, both legal counselors for the Society.

The legislative committee will vigorously oppose the use of drugs by optometrists.

Doctor Giller will determine whether the Colorado Ophthalmological Society needs $1,000 that was approved by the Section last year for the Rhode Island Ophthalmological Society which subsequently did not use it. The Colorado group has filed a class action suit against all optometrists in Colorado to stop them from diagnosing the presence or absence of glaucoma and from dispensing the legend drug known as soft lens.

FURTHER DISCUSSIONS ON HIRING A HALF-TIME ADMINISTRATIVE SECRETARY

The recommendation by Doctor Herbert Giller's committee on organization to hire a half-time administrative secretary and assess a mandatory $50 dues increase to all members of the Section on Ophthalmology was discussed further. There has been only one response from our members either for or against this proposal so far. Please write James C. Allen, MD, Eye Clinic, University Hospitals, Madison, Wis. 53706, your opinion on this increase in dues and services.

RESEARCH TO PREVENT BLINDNESS GRANT

The Medical College of Wisconsin recently announced that it has received an annual grant of $5,000 in unrestricted funds from Research to Prevent Blindness, Inc. (RPB) to speed studies of blinding diseases at the College's department of ophthalmology. The RPB grant, renewable each year, is specifically designed to promote the development of new techniques and advanced concepts in the saving of sight. Over the past five years, RPB has awarded $25,000 in similar grants to the medical school.

Dr. Richard O. Schultz, head of ophthalmology at the medical college, pointed out that the unrestricted award differed from traditional grants, giving maximum freedom to implement important research activities for which other funds are not available.

UW RESIDENTS COMPLETE TRAINING

Four residents completed training at the University of Wisconsin September 1. Dr. Jane Blockman will take a uveitis fellowship at the University of California in San Francisco. Dr. Burton J. Kushner will take a pediatric ophthalmology fellowship in Miami, Fla. Dr. Jerome G. Kadell will join the Dean Clinic in Madison. Dr. Ross Mueller will join MDs Edward J. Zeiss and John C. Zeiss in Appleton.

NEW OPHTHALMOLOGIST IN MENOMONIE

Carroll Rund, MD, a native of Finley, N.D., has joined the Red Cedar Clinic in Menomonie in the practice of ophthalmology. He fills a vacancy created by the retirement of A. A. Drescher, MD.

Doctor Rund completed his undergraduate work and basic medical sciences at the University of North Dakota, Grand Forks, received his medical degree from the University of Minnesota in 1967 and interned at St. Paul-Ramsey Hospital.

After serving two years with the U.S. Public Health Service in Detroit, Doctor Rund obtained a residency in ophthalmology at the University of Minnesota and was graduated from that three-year training program this past June.

REPORT TO SECTION

Dr. James C. Allen, chairman of the Section on Ophthalmology, will give a report to members of the Section following the business meeting Sunday, October 7, of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology at Green Bay.

Members will be brought up to date on pending legislation, medical care insurance plans, and discuss the recommendation by the Section's organization committee to assess each member of the Section $50 annually to hire a half-time administrative secretary. □

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestotions ond anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13. Beeson, P. B. and McDermott, W. eds. Philodelphio, W. B. Sounders Co., 1971, p. 1816.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 20, 1973

NEW MEMBERS

Abadeer, Samir L., 400 East Thomas St., Wausau 54401
Barash, Harvey L., 30 South Henry St., Madison 53703
Bobinski, John E., 400 East Thomas St., Wausau 54401
Calogeris, Constance M., 7635 West Oklahoma Ave., Milwaukee 53219
Carlson, Thomas J., 80 Sheboygan St., Fond du Lac 54935
Choudhuri, Bishnu P., 222 Oak St., Spooner 54801
Elliott, John T., 80 Sheboygan St., Fond du Lac 54935
Gabby, Samuel L., Jr., 720 East Wisconsin Ave., Milwaukee 53202
Gelfman, Morris, 9191 Watertown Plank Rd., Milwaukee 53226
Korbitz, Bernard C., 1313 Fish Hatchery Rd., Madison 53715
Kuglitsch, John F., 80 Sheboygan St., Fond du Lac 54935
Lent, John E., 80 Sheboygan St., Fond du Lac 54935
Massick, Stephen A., 8700 West Wisconsin Ave., Milwaukee 53226
O'Connor, Richard C., 400 East Thomas St., Wausau 54401
Reichert, John R., 6201 Pioneer Rd., Madison 53711
Roberts, Thomas N., 1836 South Ave., La Crosse 54601
Romero, Ruben P., 2962 North 61st St., Milwaukee 53210
Rugowski, James A., Cumberland 54829
Schmitz, Peter W., 105 Castille Ave., Madison 53713
Utley, Henry G., 5218 North Lovers Lane Rd., Milwaukee 53225
Wagner, Thomas R., 2040 West Wisconsin Ave., Milwaukee 53233
Watts, Edwin S., 2500 Mayfair Rd., Milwaukee 53226
Young, William W., 104 Adams Street South, St. Croix Falls 54024

CHANGE OF ADDRESS

Andrews, Walter C., Frederic 54837
Ayengar, Shanta, 101D Eagle Heights Apts., Madison 53705
Barina, Henry J., 2214 Washington Ave., Racine 53405
Becker, Dean B., Jr., 400 Ceape Ave., Oshkosh 54901
Bourne, Warren 700 North Water St., Milwaukee 53202
Bourne, Richard, 700 North Water St., Milwaukee 53202
Cabaltica, J. B., P. O. Box 34, Baraboo 53913
Chase, Samuel L., 1054 Woodrow St., Madison 53711
Curran, William P., Route #2, Deerbrook 54424
Darvin, Theodoro A., 237 Wisconsin Ave., Waukesha 53186
D'Cunha, George F., 7896 North Club Circle, Fox Point 53217
Drescher, Aubrey A., Sister Bay 54234
Elconin, Arnold N., 1218 West Kilbourn Ave., Milwaukee 53233
Farkas, Mary E., 1305 South 10th St., Manitowoc 54220
Feulner, Robert C., 611 Westminister, Waukesha 53186
Gascoigne, Clarence C., Route #2, Friendship 53934
Goodman, Paul P., 1218 West Kilbourn Ave., Milwaukee 53233
Gorenstein, Leonard, 1218 West Kilbourn Ave., Milwaukee 53233
Gross, William S., Bliss Army Hospital, Dept. of Surgery, Fort Huachuca, Ariz. 85613
Gulyn, Anna B., 25 Spicewood Lane, Salisbury, North Carolina 28144
Gulyn, Bohdan E., 25 Spicewood Lane, Salisbury, North Carolina 28144
Hansen, Duwayne A., 832 South Hampton St., Fairmont, Minn. 56031
Harris, Beryl A., 8008 West Capitol Dr., Milwaukee 53222
Hidde, Frederick G., Medical Dept. Kohler Company, Kohler 53044
Hirschboeck, John S., 3948 North Harcourt Place, Milwaukee 53211
Hitz, John B., 2040 West Wisconsin Ave., Milwaukee 53233
Hodgson, Norman B., 700 North Water St., Milwaukee 53202
Hoops, Harold J., Jr., 704 South Webster, Green Bay 54301
Jacobs, Edmund B., 704 South Webster, Green Bay 54301
Jerofke, Alfred, 4379 South Howell Ave., Milwaukee 53207
Johnson, J. Howard, 2023 Evergreen Lane, Hartland 53029
Johnson, Larry W., R. R. #1, Lancaster 53813
Kennedy, Brian W., 8700 West Wisconsin Ave., Milwaukee 53226
Kleiman, Martin M., 8736 Palmetto Ave., Milwaukee 53218
Korst, Donald R., 333 North Randall Ave., Madison 53706
Kuter, David P., 703 - 14th St., Baraboo 53913
Lass, Thomas E., 2680 Woodglen Court, Brookfield 53005
Lawrence, Paul J., P. O. Box 351, Janesville 53545
Levy, Stuart A., 9509 North Wakefield Court, Milwaukee 53217
Locher, Charles J., 2652 North Lake Dr., Milwaukee 53211
Mansell, Frederick T., 701 Terraview Dr., Green Bay 54301
McDuffie, James J., 3700 North 27th St., Milwaukee 53216
Morgan, James E., 6063 North Kent Ave., Milwaukee 53217
Nefches, M. S., 1601 - 43rd St., North, St. Petersburg, Fla. 33713
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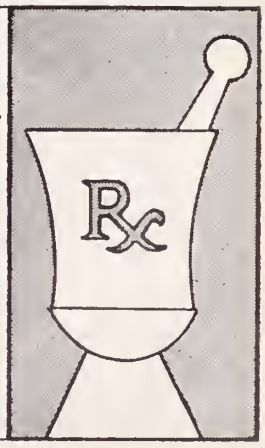

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Sholtes, Clause A., 1208 Charles St., Fort Atkinson 53538
Singh, Satnam, 149 Old Pine Circle, Racine 53402
Smith, David A., 23 West Milwaukee St., Janesville 53545
Steen, Marvin H., 48 Country Club Lane, Oshkosh 54901
Stiennon, O. A., Jr., 2227 Van Hise Ave., Madison 53705
Stoll, William M., 1905 Rainbow Ave., DePere 54115
Strickland, Samuel A., Holbrook St., Danville, Va. 24541
Sweet, David F., 80 Sheboygan St., Fond du Lac 54935
Sy, Santiago T., 9555 South Howell Ave., Oak Creek 53154
Talbot, Allan E., P. O. Box 596, Minocqua 54548
Tanner, William A., c/o Robin Barnes, Verona 53593
Tarver, Milton G., 3660 North Teutonia Ave., Milwaukee 53206
Tibbets, James C., 20 South Park St., Madison 53715
Tiu, Alfonso L., 10617 West Oklahoma Ave., West Allis 53227
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Van Susteren, John A., 3550 Mormon Coolee Rd., La Crosse 54601
Victoria, B. M., Jr., 740 North Plankinton Ave., Milwaukee 53203
Villalobos, Enrique, 130 Warren St., Beaver Dam 53916
Wadina, Gerald W., 5820 South Packard Ave., Milwaukee 53207
Waisman, Raymond C., 2040 West Wisconsin Ave., Milwaukee 53233
Wichman, Harvey M., 2040 West Wisconsin Ave., Milwaukee 53233

DEATHS

Toepfer, Raymond A., Milwaukee County, May 16, 1973
Wood, Cordelle A., Waukesha County, May 24, 1973
Freymiller, Ernest F., Grant County, May 25, 1973
Meyer, Julius M., Milwaukee County, May 27, 1973
Gulbrandsen, Lars F., Vernon County, May 30, 1973
Regan, Joseph M., Milwaukee County, June 2, 1973
Rose, Joseph F., Oconto County, June 7, 1973
Santos, Geronimo P., Outagamie County, June 10, 1973
Williams, Claiborne, nonmember, June 13, 1973
Graner, Leonard H., Marinette-Florence County, June 17, 1973
Hahn, Anthony C., nonmember, June 21, 1973
Reese, Hans H., Dane County, June 23, 1973
Adams, Robert W., Barron-Washburn-Sawyer-Burnett County, June 25, 1973 □

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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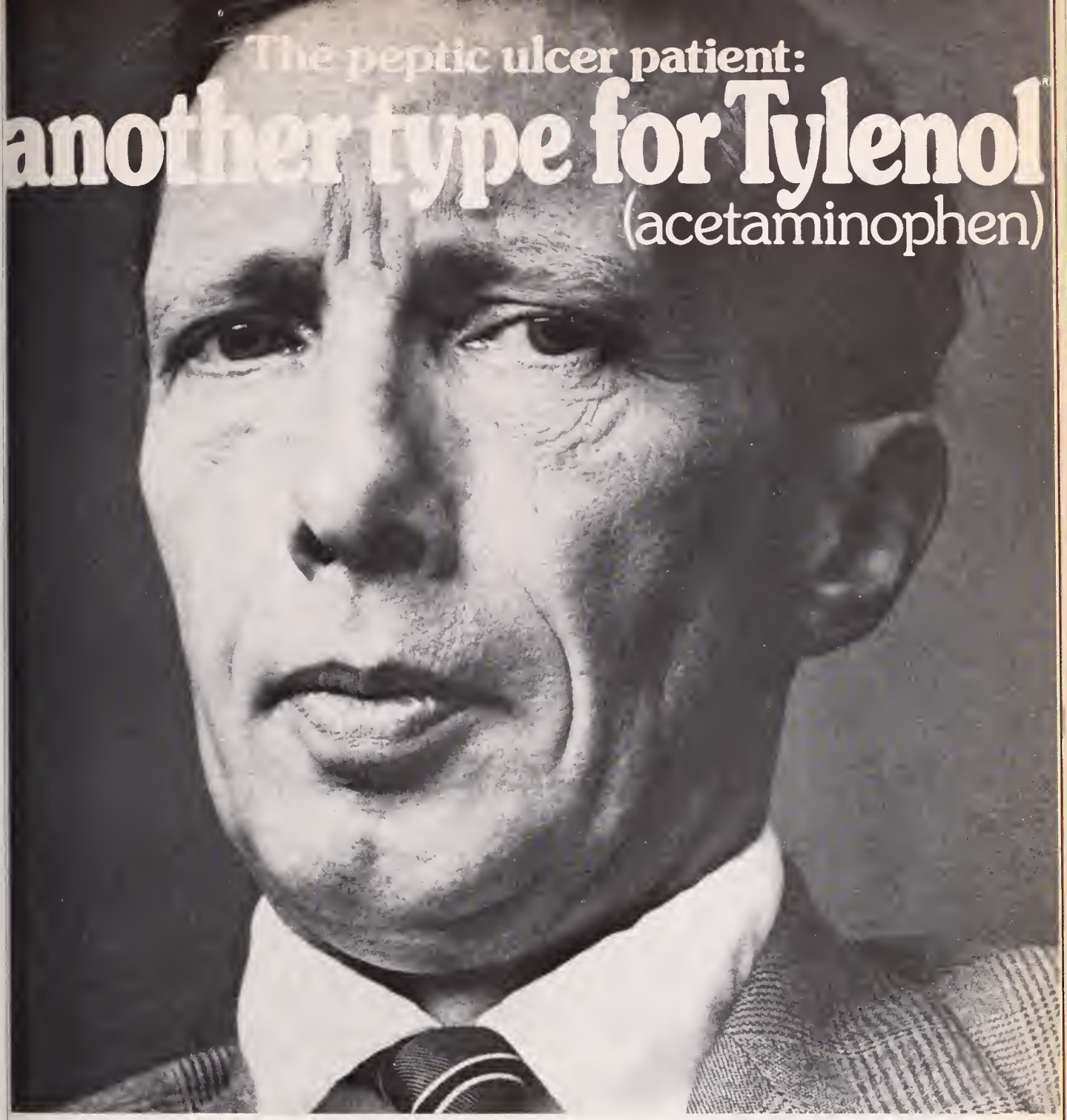

When the peptic ulcer patient has a condition requiring an analgesic, a new problem arises. Aspirin is a gastric irritant that plays a significant role in the exacerbation of ulcer symptoms.[1,2]

TYLENOL (acetaminophen), on the other hand, is unlikely to irritate the gastric mucosa and is usually preferred in the presence of peptic ulcer.[1,3]

The peptic ulcer patient is only one of several 'types for TYLENOL' —that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Vickers, N.F.: Gastroint. Endosc. *14*:94-99 (Nov.) 1967. **2.** Muir, A., and Cossar, I.A.: Brit. Med. J. *2*:7-12 (July 2) 1955. **3.** Craddock, D.: Practitioner *189*:192-200 (Aug.) 1962.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
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Chewable Tablets, 120 mg.

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(acetaminophen)

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OBITUARIES

Stephan A. Konz, MD, 64, Appleton, died Apr. 16, 1973 in Appleton.

Born on Dec. 7, 1908 in Rib Lake, Wis., Doctor Konz graduated from Marquette University School of Medicine in 1935 and served his internship at St. Elizabeth Hospital in Appleton. Doctor Konz served in the United States Army Medical Corps during World War II and was stationed in England. He was a staff member of St. Elizabeth's Hospital, on the board of directors of Family Heritage Nursing Home and Oak Ridge Gardens Nursing Home.

He was a member of the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Helen; one daughter, Mrs. Gerald Simon, Sun Prairie; three sons, Stephan, Manhattan, Kan.; Christopher, Appleton; and Jonathan, Langley Air Force Base, Va.

Clifford Y. Wiswell, MD, 67, Williams Bay, died Apr. 28, 1973 in Williams Bay.

Born on Aug. 4, 1905 in Elkhorn, Wis., Doctor Wiswell graduated from the University of Wisconsin Medical School in 1930 and served his internship at Milwaukee Passavant Hospital. Doctor Wiswell had practiced in Williams Bay since 1931.

He was a member of the Walworth County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Beatrice, and one daughter, Mrs. Robert Pegel, Williams Bay.

Charles E. Wall, MD, 73, health commissioner of Manitowoc for 34 years, died May 5, 1973 in Melbourne, Fla.

Born on Oct. 9, 1899 in Antigo, Wis., Doctor Wall graduated from Marquette University School of Medicine in 1930 and served his internship at St. Elizabeth's Hospital in Youngstown, Ohio. Doctor Wall was on the medical staff of Holy Family and Manitowoc County Memorial hospitals.

He was a member of Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Dorothy; two daughters, Mrs. Sarah Schiegg, Milwaukee, and Miss Patricia, Brattleboro, Vt.; and three sons, Charles Jr., Manitowoc; Thomas, Kimberly; and Michael, La Crosse.

Cordelle A. Wood, MD, 74, Waukesha physician for 44 years, died May 24, 1973 in Waukesha.

Born on Aug. 3, 1898 in La Moille, Ill., Doctor Wood graduated from the University of Illinois Medical School in Chicago in 1923 and served in the United States Army Medical Corps during World War II. Doctor Wood served as staff doctor at Carroll College for 20 years and also was former chief of staff at Waukesha Memorial Hospital. He was a member of the American Academy of Family Physicians and the American College of Surgeons.

He was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Winifred; two daughters, Mrs. Henry (Yvonne) Golsteyn, West Allis; Mrs. William (Mary Ann) Voellings, Mukwonago; and two stepdaughters, Mrs. Louis (Pat) Dellios, Waukesha and Mrs. Dean (Polly) Blazek, Antigo.

Ernest F. Freymiller, MD, 78, founder of the Boscobel Clinic, died May 25, 1973 in Boscobel.

He attended the University of Wisconsin and the University of Minnesota, receiving his medical degree in 1922. He served his internship at the University of Minnesota. Doctor Freymiller practiced in Minnesota until 1930 when he returned to Boscobel. In 1969 the Boscobel community had a "Doc Freymiller" day honoring him for his contributions to the area. In 1972, the State Medical Society of Wisconsin inducted him into the "50 Year Club" honoring him for his long service.

He was a member of the Grant County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Erna; and a daughter, Mrs. Thomas Black, Rossville, Ill.; and a son, Theodore, Holly, Mich.

Joseph M. Regan, MD, 60, Milwaukee, died June 2, 1973 in Milwaukee.

Born on Jan. 2, 1913 in Milwaukee, Doctor Regan graduated from Marquette University School of Medicine in 1941 and served his internship and residency at Milwaukee County General Hospital and the Mayo Clinic, Rochester, Minn., respectively. He was a member of the Milwaukee Orthopedic Society, American College of Surgeons, and American Academy of Orthopedic Surgeons.

He also was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Eleanore; and two children, Colin and Kathleen.

Charles E. Wall, MD

As the last persons filed past the grave, and family, relatives and friends left the cemetery to return to their busy lives, I thought a lot about Dr. Charles Wall and what he had meant to the community, to all his patients who knew him and loved him through the years, and especially to his colleagues in the medical profession in the county as well as in the State Medical Society.

Here was a man of real humility and understanding, always vitally interested in all whom he had daily contact with. I cannot recall him ever speaking a word of criticism or unkindness against anyone. He served his patients with a complete dedication and with sacrifice.

Dr. Wall had a great sense of humor, a hearty laugh and a warmness of personality that will be unforgettable. He loved sports and was a devoted and loyal high school basketball fan and a longtime Packer fan, rarely missing a home game.

Dr. Wall was intensely interested in his profession and despite his busy practice he found time to attend hospital staff meetings as well as county and state medical meetings and fulfill the education requirements of the Academy of General Practice.

Yes, we physicians will truly miss "Charley," and I join with them in wishing him farewell. May we all profit by his example!—Daniel M. Pick, MD in a letter-to-the-Editor of the *Manitowoc Herald Times*, May 21, 1973.

Geronimo P. Santos, MD, 43, Appleton, died June 10, 1973 in Appleton.

Born on May 11, 1930 in the Philippines, Doctor Santos graduated from the University of Santo Tomas in 1955 and served his internship at St. Joseph's Hospital, Lowell, Mass. His residency was taken at Mount Sinai Hospital, Milwaukee, Wis., and the University of Minnesota Hospital, Minneapolis, Minn. Doctor Santos served as head of the Department of Anesthesiology of Appleton Memorial Hospital since 1961 and also was on the medical staff of St. Elizabeth's and Theda Clark hospitals in Neenah. He was a member of the Fox Valley Anesthesiologist, S.C. in Appleton.

Doctor Santos was one of the founders of the Jose P. Rizal Memorial Foundation, a Philippine medical relief organization, and a past officer of the Filipino-American Medical Association. He also was a member of the International Anesthesia Research Society, Wisconsin Society of Anesthesiologists, American Society of Anesthesiologists, Fox Valley Academy of Medicine, and the American Association of Foreign Medical Graduates.

He was a member of the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Patricia; two daughters, Kim Marie and Michelle, and one son, Tony.

Leonard H. Graner, MD, 85, prominent Coleman physician died June 17, 1973 in Oconto.

Born on Sept. 4, 1887 in Green Bay, Wis., Doctor Graner graduated from the University of Illinois School of Medicine in 1910, and served his internship in Chicago. He practiced in Pound, Wis. from 1912-1918 and moved to Coleman in 1918 where he practiced until his retirement. Doctor Graner served as health officer of Pound and Coleman for over 40 years. In 1960 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin.

He also was a member of the Marinette County Medical Society and the American Medical Association.

Surviving is his widow, Josephine.

Anthony Charles Hahn, MD, 67, retired Watertown physician, died June 21, 1973 in Watertown.

Born on Feb. 18, 1906 in Watertown, Doctor Hahn graduated from Northwestern University School of Medicine in 1932 and served his internship at St. Mary's Hospital, Madison. He established his practice in Watertown until ill health forced his retirement a few years ago. After his retirement, Doctor Hahn served as physician for the residents of Marquardt Memorial Manor in Watertown.

Surviving are his widow, Harriet; one daughter, Mrs. Terry (Andrea) Turke, Madison; two sons, Peter A. Hahn, Grosse Pointe, Mich. and Dr. Michael F. Hahn, Sun Prairie.

Hans H. Reese, MD, 81, Madison, internationally known University of Wisconsin neurologist and psychiatrist, died June 23, 1973 in Madison.

Born on Sept. 17, 1891 in Bordesholm in Holstein, Germany, he graduated from the University of Kiel in 1917 and did postgraduate work at the University of Hamburg. He came to the United States in 1920 and in 1925 he helped found the neuropsychiatry department at the University of Wisconsin Medical School, Madison. He was chairman of the department in 1940, 1946, and 1954-1956, and of the neurology department from 1956-1958.

Doctor Reese was a special consultant to the Institute of Neurological Diseases and Blindness of the National Institutes of Health to Tokyo, Japan, in 1959. In 1965, he received an honorary degree from Kyushu University in Japan. In 1961, he was a Fullbright professor and lecturer at the University of Alexandria, Egypt.

Doctor Reese retired as a professor emeritus from the University of Wisconsin in 1962.

In 1968, Doctor Reese became a member of the "50 Year Club" of the State Medical Society of Wisconsin. He was member of the House of Delegates of the AMA for many years, president and fellow of the College of Psychiatry, and president of the Milwaukee and North Central Neuropsychiatry Societies. He had served as president of the American Muscular Dystrophy Association, the American Neurological Association, and the American Board of Psychiatry and Neurology. He also was a former secretary of the Dane County Medical Society.

Surviving are his widow, Tessa; a son, Ernst, Hawaii; and two daughters, Mrs. Sibyl R. Millner, Monkton, Md. and Mrs. Alma R. Gray, Pasadena, Calif.

Robert Warren Adams, MD, 91, Chetek physician for 40 years, died June 25, 1973 in Rice Lake, Wis.

Born on Mar. 9, 1882 in Columbia County, Wis., Doctor Adams graduated from the University of Minnesota School of Medicine in 1923 and served his internship at Minneapolis General Hospital, Minneapolis, Minn. Prior to graduation from medical school, Doctor Adams had been principal and superintendent of schools in several Wisconsin communities. He retired in 1966 after serving the Chetek area since 1926.

He was a member of the Barron-Washburn-Sawyer-Burnett County Medical Society, State Medical Society of Wisconsin, American Medical Association, and the American Academy of Family Physicians.

Surviving are his widow, Thelma; and two daughters, Mrs. Bruce (Louise) Balken, Ogden, Utah and Mrs. Robert (Elizabeth) Moe, Geneva, Switzerland.

Stephan Epstein, MD, 73, internationally known dermatologist and founder of the Marshfield Clinic Foundation, died June 30, 1973 in Madison.

Born on Mar. 14, 1900 in Nuernberg, Germany, Doctor Epstein graduated from the University of Erlangen in Nuernberg in 1923 after educational stays at universities in Munich, Berlin, Breslau, and Heidelberg. He served his internship at City Hospital in Nuernberg and his residency training at the University Skin Clinic, Breslau, Germany. He was chief of the department of radiology and allergy in Breslau from 1930 to 1935. Doctor Epstein came to the United States in the late fall of 1935, and came to the Marshfield Clinic in the spring of 1936, establishing the Department of Dermatology. While at the Clinic, he served as professor of dermatology at the University of Minnesota and the University of Wisconsin.

Doctor Epstein was founder of the Marshfield Clinic Foundation for Medical Research and Education which was established in 1959 and served as president of the Foundation for six years. He retired in 1965 from the Clinic and opened a private practice in Madison. Doctor Epstein enjoyed an international reputation for his excellence in both clinical dermatology and dermatologic research.

He was a member of the American Dermatological Association, American Academy of Dermatology, American College of Allergies, Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Elsbeth; and two sons, Drs. Ernest, San Mateo, Calif., and Wolfgang, Chicago.

Dr. Stephan Epstein

The afflicted in two countries, Germany and the United States, benefitted from the talented dedication of Dr. Stephan Epstein, an internationally known dermatologist, who died here Saturday at the age of 74.

He came to the U.S. from his native Germany in 1936, and associated with the famed Marshfield Clinic where he quickly established himself as a leading researcher in skin diseases. While associated with the Marshfield Clinic, Dr. Epstein served concurrently as professor of dermatology at the University of Minnesota and the University of Wisconsin.

He was a delightful conversationalist, an avid reader, the author of more than 200 scholarly papers, and a lover of fine music.

After retiring from the Marshfield Clinic, he opened a private practice in Madison. He and his wife, Elsbeth, were familiar couples at this city's varied music concerts.

He is mourned in at least two countries, two states and two cities. That speaks enough of his talents and his humanity.—Reprinted from The Madison *Capital Times,* July 3, 1973.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

TENTATIVE SCHEDULE

Orthopedic Field Clinics

July 1, 1973—December 31, 1973

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN

Bureau for Crippled Children

Location	*Date*	*Examiner*
Ashland	Aug 23-24	WT Brodhead, MD
Stevens Point	Sept 5	JM Kirsch, MD
Racine	Sept 19-20	JR Hammes, MD
		MW Nelson, MD
Manitowoc	Sept 24-25	WF Schneider, MD
Superior	Oct 2	JG Heisel, MD
Eau Claire	Oct 8	HE Sorensen, MD
Chippewa Falls	Oct 16	JM Huffer, MD
Rhinelander	Oct 24-25	HI Okagaki, MD
Sheboygan	Nov 7-8	JJ Van Driest, MD
Kenosha	Nov 14-15	CA Sattler, MD
		AP Patel, MD

FOR: Clinics conducted by the Bureau for Crippled Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: May be obtained from the Bureau for Crippled Children and should be requested well in advance of the clinic date. Referral forms are made for each clinic so when requesting be sure to state how many are needed and for which clinic. It is important that we know in advance the number desiring clinic service so the caseload will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: We no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

ADDRESS CORRESPONDENCE: Bureau for Crippled Children, 126 Langdon Street, Madison, Wisconsin 53702.

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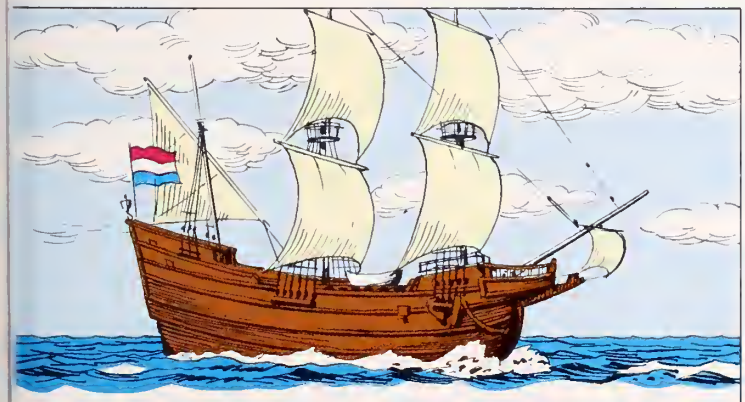

RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg

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PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

IMMEDIATE OPENING: MULTIspecialty clinic in northwestern Wisconsin is expanding; group seeking

1. Internist
2. General Surgeon
3. Allergist

Ultramodern 500-bed hospital located close to clinic. Excellent recreational area. Salary first year, corporate member thereafter. Young group, incorporated, excellent fringe benefits, including qualified profit-sharing plan. Contact Dept. 396 in care of the Journal. 6tfn/73

JANESVILLE MEDICAL CENTER. Four family physicians desire additional partners. New hospital. Delightful living and practice conditions. Contact: G. L. Apfelbach, MD, 2020 East Milwaukee St., Janesville, Wis. 53545. Tel: 608/754-5581. 4-9/73

WANTED: YOUNG BOARD CERtified or board eligible Obstetrician and Gynecologist to join three-man group which is part of a multi-specialty partnership (40 physicians) in a rural Midwest community serving an area of approximately 250,000. Contact Dept. 394 in care of the Journal. 5–10/73

OB–GYN: IMMEDIATE OPENING for existing practice. Solo or group opportunity. Excellent facilities waiting. Contact G. R. Stebnitz, 5001 Monona Dr., Madison, Wis. Tel: 608/222–2521. 2tfn/73

WANTED: GENERAL PRACTItioner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $30,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Dermatology
3. General Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 54701. 7-12/73

KROHN CLINIC, LTD., NEEDS physician in rural family practice. Group practice circumstances excellent but must be in early 30s or less. Please contact William B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams Street, Black River Falls, Wis. or phone collect 715/284-4311. 7tfn/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY OF GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months.

STUDENT HEALTH SERVICE DIRECTOR

University of Wisconsin-Milwaukee is seeking an experienced MD with administrative ability to direct the Department of Student Health as well as share in providing general medical services. Qualifications: licensed to practice medicine in State of Wisconsin, AMA membership, eligibility for staff membership at Columbia Hospital, and clinical practice, preferably in internal medicine or family medicine. UW-Milwaukee is an equal opportunity employer; and in keeping with its affirmative action program, encourages minorities and females to apply for this position.

MRS. KAREN H. ROBISON
Search Committee
Cunningham Hall No. 579
University of Wisconsin-Milwaukee
Milwaukee, Wis. 53201

Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

IMMEDIATE OPENINGS FOR physicians in OB–GYN specialty to establish a successful practice in a multi-specialty clinic located close to hospitals. In-clinic medical student teaching opportunity. University and college city. Year around indoor and outdoor family activities of all types. Salary plus excellent benefits first year and corporate member thereafter. Interview expenses paid. Call collect to D. W. Shea, MD, Beaumont Clinic, Ltd., 1821 S. Webster Ave., Green Bay, Wis. 54301. p5–9/73

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

WANTED: PHYSICIANS, SPECIALists or Generalists, who want to practice medicine in a semi-rural area but still have the advantages of the state's largest cultural, population, and medical center within twenty-five minutes travel.

Discover Ozaukee County. A beautiful blend of a rural agricultural setting interspersed with growing communities which are progressive but still preserve the charm and beauty of early Wisconsin history.

Physicians are urgently needed to provide the key that will open the health-care door for the 55,000 people who call this county their home. These people are more affluent than the average in Wisconsin. They need and want physicians to enjoy living and working in this area with all its advantages.

This is a prime recreation area on the shores of Lake Michigan, just north of the hustle and bustle of Milwaukee.

St. Alphonsus Hospital in Port Washington is an orderly, modern facility ready to provide acute, general hospital care in the heart of this county community. It is ideally located in the center of Ozaukee County about 20 miles from other hospitals to the north, south, and west. A new, 12-man office building connected to the hospital will be ready by August 1, 1973, and other office space is available in most of the nearby cities and villages.

If you are interested in the good life, and a good practice, contact George Seidenstricker at St. Alphonsus Hospital, 743 N. Montgomery Street, Port Washington, Wis. 53074. Tel: 414/284–5511. 6–10/73

DIRECTOR
of
MENTAL HEALTH

We are seeking a psychiatrist to direct the Milwaukee County Mental Health Center, a comprehensive community mental health center, organized into six catchment area programs including outreach stations located within the community. 1,000 acute and long-term psychiatric beds; an ultra modern day hospital; and, a soon to be completed 180 bed inpatient resident and day care treatment center for children and adolescents. The Center is a principal psychiatric teaching resource for the Medical College of Wisconsin and has training programs for interns, residents, nurses and other students.

Requires Wisconsin licensure or eligibility for same and at least 5 years comprehensive experience as a mental health director, educator, or administrator preferably in an accredited mental health program, university or hospital.

This is a timely opportunity since we can offer the person appointed to this position the chance to make several critical appointments to new subordinate positions. Excellent employe fringe benefit program and salary. Send vita to:

EDWIN A. MUNDY,
DIRECTOR
Institutions & Departments
8731 Watertown Plank Rd.
Milwaukee, Wis. 53226

ASSISTANT MEDICAL DIRECTOR. IDS Life, a subsidiary of Investors Diversified Services, is seeking an internist or general practitioner. This is an administrative position on the Minneapolis home office staff of a rapidly growing life and disability income insurance company. Primary responsibility is for the medical evaluation of insurance applications. Ability to interpret electrocardiograms is required. Position offers advancement potential, excellent benefits, profit sharing, and expenses for relocation to Minneapolis. Send resumé in confidence to Dan Willius, 3300 IDS Tower, Minneapolis, Minn. 55402. 8-9/73

PUT IT ALL TOGETHER: THE satisfaction of rural general practice plus the joys of small town life. Join us in the fun at the Markesan Medical Center. Call 1-414/398-2321, Markesan, Wisconsin. p8-9/73

PEDIATRICIAN WANTED TO JOIN 3 pediatricians in suburban Milwaukee area. Liberal salary first year. Apply: J. R. Guy, MD, Waukesha Pediatric Assoc., 1111 Delafield St., Waukesha, Wis. 53186. 8-12/73

LAKE SUPERIOR CALLING WELL trained family practitioners, internists, pediatricians, otolaryngologist or urologist eager to practice where skills will be fully used and appreciated by the people living in Ashland and surrounding drawing area, 120,000 in all. Brand new 101-bed hospital with 5-bed ICU/CCU and extremely well equipped lab headed by full-time pathologist. Memorial Medical Center also has two full-time radiologists and complete range of x-ray facilities. Continuing education programs for medical, nursing and ancillary staffs. Other physicians practicing in Ashland: 3 ophthalmologists, 1 Ob-Gyn specialist, 1 psychiatrist, 1 internist, 1 new, busy general surgeon, and general practitioners. Progressive school system, new high school, vocational school and 4-year college. Need guarantee? A generous one is available. To arrange expense paid visit, write, sending CV to Fred Tidstrom, MD, 600 14th W., Ashland, Wis. 54806, or call collect after 6:00 pm, Ken Morrow, MD, 715/682-5321. 8-10/73

WANTED: GENERAL PRACTITIONER in city of Markesan, Green Lake County, Wis., to join two AAFP members, so that we can all enjoy more normal time for relaxation and family life. Salary first year, partnership thereafter. Contact D. P. Cupery, MD, Markesan Medical Center, P. O. Box 247, Markesan, Wis. 53946. 8tfm/73

THE MONROE CLINIC IS INTERviewing Surgical and Medical Specialists to join the present 39 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical and Surgical Specialties:

1. Urology
2. Obstetrics and Gynecology
3. Orthopedic Surgery
4. Otolaryngology
5. Family Practice
6. Gastroenterology
7. Cardiology
8. General Internal Medicine

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 9tfn/73

IMMEDIATE OPENING FOR INternist or General Practitioner to join established practice. Brand new clinic building and adequate hospital facilities. Good starting salary with partnership following year. Contact Dept. 363 in care of the Journal. 10tfn/72

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB-GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn/72

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club

with golf course. Contact Arthur R. Weihe, MD, or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel. 608/339-3326. 6tfn/72

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis. Tel.: 414/637-9271. 4tfn/72

GPs URGENTLY NEEDED TO JOIN a new four-man corporate practice located in central Wisconsin. Excellent recreational area, small town living within 40 minutes drive to Appleton and Green Bay. New fully equipped hospital and adjacent clinic facilities. Good salary, benefits with early equity. Excellent opportunity for sharing in growth development. Contact Dept. 398 in care of the Journal. 9-11/73

WISCONSIN MULTI-SPECIALTY group of 17 physicians has openings in the following specialties: Internal Medicine, presently six men, general or subspecialty training; Otolaryngology, presently one-man department; Allergy, an excellent opportunity as this specialty is not covered in our community. Attractive starting salary, no investment, corporate organization, exceptional pension and insurance programs, progressive community of 45,000. Include curriculum vitae with correspondence. For further information please contact Francis R. Russo, MD, Janesville Riverview Clinic Ltd., Box 551, Janesville, Wis. 53545. 9tfn/73

FAMILY PRACTICE OPENING January, 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreational opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, MD (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815. Tel: 509/782-1541. 9/73-8/74

WANTED: RECENTLY TRAINED radiologist to provide modern diagnostic and therapeutic radiological services for a recently consolidated midwest regional hospital of approximately 300 beds. Radiologist recently died and his part-time associate plans to retire soon. Contact Dept. 397 in care of the Journal. 9-10/73

IMMEDIATE OPENINGS FOR family practice, Ob/Gyn, pediatrics to join young expanding group. Wisconsin license or reciprocity. Top salary and fringe benefits. New clinic and excellent hospital facilities adjacent to clinic. Also solo practice available. New churches, schools, and outstanding outside recreational activities. Call collect, Les Hirt, Doctors for Medford, Medford, Wis. 54451. Tel: 715/748-4100 or 715/748-3726. 9-11/73

EXCELLENT OPPORTUNITY: GP or FP for busy established incorporated practice in thriving community of 6800. Superior educational and recreational facilities. Modern well equipped clinic adjacent 85-bed hospital. Starting salary open, partnership after one year. Phone, visit, or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372-4177. 9-11/73

PRACTICES AVAILABLE

GENERAL PRACTICE AVAILable, lucrative—sudden death; large active practice in community of 35,000 with 50,000 population in area. Well equipped 8-room office; good for one or two MDs. Contact Attorney A. A. Muchin, 1004 Washington St., Manitowoc, Wis. 54220; tel. 414/682-7713. 8-10/73

GP NEEDED TO REPLACE DEceased MD in established practice. Entire inventory for sale, excellent hospital facilities, good school in resort and recreational area. SE Wisconsin. Contact Box 457, Williams Bay, Wis. 53191. g6tfn/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

EXCELLENT PRACTICE OPPORtunity for general surgeon and pediatrician within a non-clinic structure. For further information kindly write: John J. Van Driest, MD, President, Sheboygan Medical Arts Bldg., Inc., 1226 North 8th St., Sheboygan, Wis. 53081. 8-9/73

PRACTICE FOR SALE: 30 MILES northwest of Milwaukee. Small town with access to new $4 million hospital and Milwaukee specialists. Retirement plans create this fine opportunity in a growing community. Combined residence and office plus adjoining lot for expansion. Call 414/629-5511. 8-10/73

LARGE PRACTICE AVAILABLE: Before you make any decison please see this practice. Good for two GPs. Do surgery, GP, OB-GYN. Well built and furnished practice. All recreation available right here with hospital in town. Contact Dept. 392 in care of the Journal. 8-10/73

MEDICAL FACILITIES

EXCELLENT OPPORTUNITY FOR pediatricians and internists to establish practice in beautiful new physicians condominium building adjacent to Bellin and St. Vincent hospitals in Green Bay, Wis. Patients immediately available on referral from other physicians in the building. Call or write H.F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748–3636. g4tfn/73

THE NEED CONTINUES! ! EVEN though a number of excellent physicians has come to practice in our community, *we need more doctors* . . . particularly family practitioners, internists, orthopedists, otolaryngologists, and ophthalmologists. Join others in discovering Watertown, Wisconsin. New Health Care Center includes 100-bed general hospital, connecting (but separate) medical office building, and connecting 120-bed nursing home.

Progressive and growing community. Good location between Milwaukee and Madison. Medical practice area includes 40,000 people. Good schools. Beautiful parks, trees and lakes. Stable economy.

Medical staff supporting recruitment efforts. Write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wisconsin 53094; tel. 414/261-4210. 7-9/73

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn/72

FOR SALE: 100 MILLIAMP B. E. diagnostic x-ray unit Model R 38 complete with adjustable table, table cassette, fluoroscope screen, and lead-lined gloves. Write: R. G. Yost, MD, 918 A Washington St., Manitowoc, Wis. 54220. p9/73

MISCELLANEOUS

GUIDELINES FOR BLOOD—ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

PUBLICATIONS

Guide for School Health Examinations. 40-page, 1970 revised edition, prepared and published by the State Medical Society's Division on School Health in cooperation with the Wisconsin State School Health Council, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, at cost of $1.00 per copy to be sent with order.

Narcotic Symposium. The Controlled Substances Board of Wisconsin will host a one-day technical symposium on narcotic antagonists Friday, Oct. 12. Nationally known speakers will discuss diagnostic and therapeutic uses, progress in research, clinical experiences, and federal and legal outlooks. Symposium will be held at Mendota State Hospital in Madison. Cost will be $5, covering registration, lunch, and a copy of the proceedings. Interested parties should contact Nancy Kaufman, RN, Room 523, 1 W. Wilson St., Madison, Wis. 53702 for further information.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1973 through Aug. 31, 1974 appeared in JAMA (Supplement) Aug. 13, 1973.*

1973 WISCONSIN

Oct. 2–5: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison (tentative).

Oct. 6: 19th Annual Fall Physicians Conference (Cancer Scrimmage) from 9 am to 12 noon at University of Wisconson-Madison Medical Center, SMI Bldg, Room 227. Sponsored by the American Cancer Society, UW Department of Continuing Medical Education, and the Division of Clinical Oncology.

Oct. 6: Annual Fall Meeting, Wisconsin Society of Pathologists, Bellin Memorial Hospital, Green Bay, "Pathology of the Skin." Info: J. M. B. Bloodworth, Jr., MD, VA Hospital, 2500 Overlook Terrace, Madison 53705.

Oct. 12: Narcotic Antagonist Symposium, Mendota State Hospital, 301 Troy Dr., Madison, Wis. 53704. Info: Contolled Substances Board, Rm. 523, 1 W. Wilson St., Madison, Wis. 53702.

Oct. 25-26: Conference on Helpful Chest X-Ray, ECG, and Clinical Clues to Congenital Heart Lesions; Richard H. Wasserburger, MD. Sponsored by UW Department of Postgraduate Medical Education, Madison Campus.

Oct. 26-27: "Diabetes for the Practicing Physician" seminar, Marc Plaza Hotel, Milwaukee, sponsored by the Medical College of Wisconsin's department of medicine and the Wisconsin Diabetes Association. Info: Anne T. Finnegan, Conference Planner, The Medical College of Wisconsin (Tel. 414/272-5450, Ext. 247), or N. H. Engbring, MD, 8700 W. Wisconsin Ave., Milwaukee 53226.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 10: "Physician Extension Techniques" seminar sponsored by Marshfield Clinic Foundation for Medical Research and Education, at The Theater, University of Wisconsin, Wood County Center. Francis N. Lohrenz, MD, Chairman.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

Nov. 14: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Nov. 28-Dec. 1: Conference on the First Week of Life, sponsored by Wisconsin Association for Perinatal Care, Great Plains Organization for Perinatal Health Care, University of Wisconsin, Wisconsin State Department of Health and Social Services, and Division of Maternal and Child Health Services, at the Pioneer Inn. Oshkosh.

Dec. 6: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

1973 NEIGHBORING STATES

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich

Oct. 11-13: Fourth Annual Meeting on Antibiotics and Infection, University of Iowa, Iowa City, Ia.

Oct. 15-19: 59th Annual Clinical Congress, American College of Surgeons, Chicago, Ill.

Oct. 20-24: Annual Meeting, American Academy of Pediatrics, Palmer House Hotel, Chicago, Ill.

Oct. 20–26: Annual Otolaryngologic Assembly of 1973, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Oct. 29-Nov. 1: 58th Annual Scientific Assembly, Interstate Postgraduate Medical Association, Palmer House, Chicago, Ill.

Nov. 12-14: Pulmonary Disease: Clinical, Immunological and Pathological Correlations, American College of Physicians, Mayo Clinic, Rochester, Minn.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 28-30: Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

1973 OTHERS

Sept. 28-30: "Alcoholism 1973," 4th Annual Meeting of the American Medical Society on Alcoholism, Sheraton-Valley Forge Hotel, Valley Forge, Pa. Info: American Medical Society on Alcoholism, Suite 1720, 2 Park Ave., N.Y. 10016.

Oct. 16-21: 16th Annual Scientific Meeting and Workshop of American Society of Clinical Hypnosis, Hyatt Regency Hotel, Toronto, Canada. Info: The American Society of Clinical Hypnosis, 800 Washington Ave., SE, Minneapolis, Minn. 55414.

Nov. 2-3: 20th Western Cardiac Conference, Cosmopolitan Hotel, Denver, Colo. Info: Colorado Heart Association, 1375 Delaware St., Denver, Colo. 80204.

Dec. 3-6: 10th Annual New Orleans International Postgraduate Course for Physicians on "Pulmonary Function in Health and Disease." Louisiana State University School of Medicine, New Orleans. Info: Louisiana Thoracic Society, Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130.

1973 AMA

Oct. 4–6: 14th National Conference on Physicians and Schools, LaSalle Hotel, Chicago.

Oct. 7-10: AMA Woman's Auxiliary 1973 Conference, Chicago, Drake Hotel.

Oct. 10-14: AMA Board of Trustees and Committees, Chicago, AMA Headquarters.

Nov. 29-Dec. 1: AMA Board of Trustees, Anaheim, Calif.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Jan. 9: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Jan. 26–27: Council Meeting, State Medical Society of Wisconsin, Madison.

Feb. 12-14: Wisconsin Academy of Family Physicians Winter Conference, Mt. Telemark, Cable.

Feb. 28: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

June 21-23: Wisconsin Academy of Family Physicians Annual Meeting, Abbey, Fontana.

1974 NEIGHBORING

Mar. 18-21: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

Apr. 15-19: Clinical Endocrinology: Recent Advances in Diagnosis and Treatment, American College of Physicians, Mayo Clinic, Rochester, Minn.

May 19-31: Cardiac Auscultation, American College of Physicians, Mayo Clinic, Rochester, Minn.

June 10-12: New Diagnostic and Therapeutic Modalities in Internal Medicine, American College of Physicians, University of Iowa, Iowa City, Ia.

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

☐ Copy deadline for MEDICAL MEETINGS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

MEDICAL MEETINGS . . .

1974 OTHERS

Jan. 22-24: 3rd Annual Pediatric Pulmonary Course, Louisiana State University Medical Center, New Orleans, La. Info: W. Findley Raymond, Exec. Dir., A.L.A. of La., Inc., 333 St. Charles Ave., Suite 1504, New Orleans, La. 70130.

Jan. 26-Feb. 9: 15th Postgraduate Medical Seminar Cruise, Dept. of Postgraduate Medicine of Albany Medical College. Info: Frank M. Woolsey Jr., MD, Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

May 3-17: 26th Annual Congress and Teaching Seminar of the International Academy of Proctology, Montreux and Zurich, Switzerland. Info: Executive Offices, 147-41 Sanford Ave., Att: Alfred J. Cantor, MD, Exec. Sec., Flushing, N.Y. 11355.

1975 WISCONSIN

Apr. 7-8: Annual Meeting, State Medical Society of Wisconsin, Marc Plaza Hotel, Milwaukee.

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Physician Extension Techniques. A seminar to be held November 10 in Marshfield under the direction of Francis N. Lohrenz, MD, chairman of St. Joseph's Hospital-Marshfield Clinic Physicians' Assistants Committee and program director of the Physicians' Assistants School of the Marshfield Clinic Foundation.

Various ways to increase physician productivity in the delivery of health care have been suggested. New categories of health personnel are being proposed and trained. The education of the physician in the delegation of some portion of his practice to such "physician extenders" has often been neglected.

This seminar proposes to demonstrate in day to day practice how such utilization of allied health personnel can occur. In addition medico-legal issues will be discussed. Some aspects of active training programs for such personnel will be presented.

The program follows:

8:15 AM—Registration

Robert Payne, BSN—Moderator of morning session

9:00—Welcome, by David J. Ottensmeyer, MD

9:05—The Physician Assistant and Other Physician Extenders—An Overview, by Francis N. Lohrenz, MD

9:35—Experience With Physician Assistants in Two Rural Communities, by William Stanhope, BS Med

10:30—Physician Extension Techniques in Internal Medicine, by Thomas F. Nikolai, MD and Wladyslaw Z. Zurek, MD

11:10—Physician Extension Techniques in Surgery, by Ben R. Lawton, MD; David J. Ottensmeyer, MD; and Robert Intress, PA

12:00 NOON—Lunch

Robert Intress, PA—Moderator of afternoon session

1:30—Physician Extension Techniques in Pediatrics, by H. James Nickerson, MD

2:00—The Physician Assistant Program in Marshfield, by Robert Payne, BSN

2:40—The Legal Status of the Physician Assistant, by Representative John Oestreicher

3:20—Problems and Perspectives: The Physician Extender over the Next Ten Years, by William Stanhope, BS Med

The seminar will be held in The Theater, University of Wisconsin, Wood County Center. Registration fee: $5.00. Program acceptable for six (6) elective hours by The American Academy of Family Physicians. Reservations to: Mrs. Janet Knauf, Marshfield Clinic, 630 South Central Ave., Marshfield, Wis. 54449.

* * *

Diabetes for the Practicing Physician, a one and a half day seminar designed to provide physicians with current concepts in diagnosis and treatment of diabetes, is being offered by the Medical College of Wisconsin's department of medicine through the office of continuing education. It is co-sponsored by the Wisconsin Diabetes Association.

The seminar to be held October 26-27 at the Marc Plaza Hotel, Milwaukee, will emphasize practical aspects of management as well as current research and expectations. The course is approved for 10 hours of prescribed credit by the American Academy of Family Physicians.

Guest faculty include Ann M. Lawrence, MD, PhD, and Arthur H. Rubenstein, MD associate professors of medicine, University of Chicago, Pritzker School of Medicine; and Roger H. Unger, MD, professor of medicine, The University of Texas, Southwestern Medical School of Dallas.

Norman H. Engbring, MD, professor of medicine, and Ronald K. Kalkhoff, MD, associate professor of medicine of the Medical College of Wisconsin are course directors.

Further information can be had by contacting the course directors at 8700 W. Wisconsin Avenue, Milwaukee 53226; tel. (414) 258-2040 Ext. 2424, or Anne T. Finnegan, Conference Planner, The Medical College of Wisconsin; tel. (414) 272-5450 Ext. 247).

Hypertension—Its Dangers, Treatment, and Diagnosis. Symposium for physicians. Presented by University of Wisconsin—Extension, Department of Continuing Medical Education, Health Sciences Program Area. Friday-Saturday, October 12-13, at The Wisconsin Center, 702 Langdon St. Madison.

Conference objectives: To provide practicing physicians with 1) a clear awareness of the dangers of hypertension, 2) a simple sequence of diagnostic tests for the known causes and the damaging effects of hypertension, and 3) a straightforward approach to therapy in curable, mild, or severe hypertension.

Conference chairman: Theodore Goodfriend, MD.

Speakers: Harriet Dustan, MD, Vice Chairman, Research Division, Cleveland Clinic, Cleveland, Ohio; James Hunt, MD, Professor of Medicine, Mayo Medical School, Associate Director, Division of Education, Mayo Foundation, Rochester, Minn.; Norman Kaplan, MD, Professor of Medicine, University of Texas, Medical School at Dallas, Tex.; James Melby, MD, Professor of Medicine, Head, Section of Endocrinology and Metabolism, Boston University Medical Center, Boston, Mass.; Jeremiah Stamler, MD, Professor and Chairman, Department of Community Health and Preventive Medicine, The Medical School, Northwestern University, Chicago, Ill.; and Harold Itskovitz, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee, Wis.

Registration fee: $30, covers tuition, materials, three coffee breaks, a luncheon, and any necessary transportation. Fee is refundable in full if cancellation is received 24 hours prior to the start of the conference. Send registration and check to: Coordinator of Continuing Medical Education, The Wisconsin Center, 702 Langdon Street. Madison, WI 53706. Make checks payable to University Extension. For info call 608/263-2855.

Football: Ohio State vs Wisconsin, Oct. 13. Tickets can be requested in advance from the Athletic Ticket Office (1440 Monroe Street) at $7.00 per ticket.

University of Wisconsin Center for Health Sciences Faculty: Theodore Goodfriend, MD, Associate Professor of Pharmacology and Internal Medicine; David Graham, MD, Chairman, Department of Internal Medicine; Frank Gutmann, MD, Director, Hypertension Clinic; and Ernest

Continued on page 58

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin Extension/Madison 1973-1974

ON-CAMPUS CONFERENCES in Continuing Medical Education

Oct. 6: *Fall Physicians Cancer Conference* (American Cancer Society)

Oct. 12-13: *Hypertension*

Oct. 25-26: *Helpful Chest X-Ray, ECG and Clinical Clues to Congenital Heart Lesions*

Nov. 29-30: *Quality of Care Conference*

Jan. 25-26: *Exercise—As Therapeutic Tool*

Apr. 24-26: *Sports Education*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

STATE MEDICAL SOCIETY OF WISCONSIN

OFFICIAL CALL
for Scientific Exhibits

1974 ANNUAL MEETING, MILWAUKEE

March 25-26

Pfister Hotel — Scientific Exhibits and Program

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1974 Annual Meeting. The exhibits will be located in **Milwaukee.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1974 meeting are requested to file an application before *Oct. 1, 1973,* giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Space assignments will be made as exhibits are approved by Commission on Scientific Medicine.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Fiberglass draping and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, electrical connections, shelving or tables, and special lighting equipment (rented through Badger Exposition Service, Inc., Milwaukee, on form to be furnished all exhibits scheduled).

Booths for scientific exhibits will have fiberglass background, 8′ in height, and 8′ fiberglass side dividers. *No exhibit may exceed a height of 7′ from the floor.* Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level through Badger Exposition Service, Inc.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: OCT. 1, 1973.**

Address your communications to:

MARTIN Z. FRUCHTMAN, MD
Chairman of Scientific Exhibits
c/o State Medical Society of Wisconsin
Box 1109
Madison, Wis. 53701

USE FORM ON FOLLOWING PAGE →

STATE MEDICAL SOCIETY OF WISCONSIN

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBITS

1974 Annual Meeting, Milwaukee — March 25-26

Pfister Hotel — Convention Center, 7th Floor

Scientific Program and Exhibits

★

Fill out the following information and mail to:

Chairman of Scientific Exhibits
1974 Annual Meeting
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

1. Title of exhibit: .....

2. Description of exhibit (space allowed below for up to 200 words for description insertion in Annual Meeting Program):

3. Feet Required: ..... (Important: In figuring feet, remember space is 8′ deep and your exhibit can use sides as well as back. *Space is limited this year, so please request only what is essential!)*

4. Will radiologic viewing boxes be used? If so, will you furnish? .....
(The State Medical Society does *not* have equipment of this type.)

5. Name (s) of exhibitor (s): Please list titles (MD, PhD, RN, etc.); this is very important!

Please print names and titles here	Address (also indicate zip code)
.....	.....
.....	.....
.....	.....

6. Name of institution (s) cooperating in exhibit:.....

.....Street Address: .....

City: .....Zip Code: .....

DEADLINE: All applications must be filed before *Oct. 1, 1973.* Assignments will be made following that; and you will be notified.

CONTRIBUTIONS—CES FOUNDATION
July 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1973:

Unrestricted

John Allen, MD
27 SMS members voluntary contributions

Restricted

1 SMS member voluntary contribution—*Student Loans*
1 SMS member voluntary contribution—*Charitable-Disabled Physicians*
2 SMS members voluntary contributions—*Other than CESF Projects*
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Reynolds, MD, Director, Clinical Cardiology Section.

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Two-week Programs for Obstetric and Pediatric Nurses. Sponsored by the Wisconsin Division of Health, Maternal and Child Health Section, PO Box 309, Madison WI 53701.

1973-1974 schedule:

Maternity Nursing Program for Graduate Nurses—Labor and Delivery, Virginia Mecikalski, RN, Director, Marquette University College of Nursing, 3029 North 49th Street, Milwaukee WI 53210:

September 17-19, 1973
October 15-27, 1973
November 5-17, 1973
February 4-16, 1974
March 11-23, 1974
April 29-May 11, 1974

Pediatric Nursing Program for Graduate Nurses (Madison General Hospital), Mary Beckman, RN, Director, Community Health Services. Division of Health, PO Box 309, Madison WI 53701:

October 15-26, 1973
December 3-14, 1973
February 4-15, 1974
March 11-22, 1974
April 22-May 3, 1974

For brochure describing these programs, nurses should see their Director of Nurses or write to the program directors mentioned above. Registration should be made as early as possible since enrollment is limited.

Sponsors are emphatically urging more than one nurse from a hospital to attend these training sessions.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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the wisconsin medical journal

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage. 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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"Prescription drugs – who should determine the maker?"

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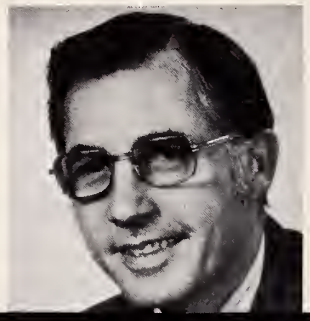
American Pharmaceutical Association



"Too many doctors are indiff ent to the economic consequence their decisions." So stated a recen issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasin game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated i crease in Blue Shield rates, Dr. Bla ingame's newsletter had this to say

"In general, it can be said, MI have given the impression they are not particularly concerned with the increase in cost of health care to th patients...

"True, an MD's training is primarily scientific, but in the real wo of practice, all of his scientific deci sions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attention Concern for economics of medicin

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inter ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmaci made in the absence of clinical kno edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

Advertisement

uld be an obligation of medical ctice...

"Medical societies ought to con- t continuing campaigns to point the substantial savings that could realized thru deductible insurance d protection for catastrophic ill- ss. At the very least, they should, in patients' interest, question the tics of any insurance organization t raises health care costs by forc- policyholders to buy insurance y may not need or want and prob- y won't ever use.

"Too many doctors are indiffer- t to the economic consequences of ir decisions. Too many, for ex- ple, habitually hospitalize patients the convenience of the MD. It's nsense to deny such habits exist...

"Doctors, thru their medical so- ties, have unhesitatingly appealed their patients for support in the ht against government interference th the private practice of medicine. d the public in the past has re- onded. It's time the American Med- l Association and state and local edical societies paid off the debt by cisive action to hold down the cost medical care."

st of Drugs

Insurance rates and hospital arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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30 drugs that he selects to treat the ajority of conditions encountered in s practice. Moreover, the physi- an's choice of a specific brand is sed on his knowledge of the pa- ent's medical history and current ndition, and his experiences with e particular manufacturer's oduct.

Some substitution proponents ave argued that the dispensing of a escription is a simple two-party ansaction between the pharmacist nd the patient, and that a substitut- g pharmacist may avoid even a chnical breach of contract by simply otifying the patient that he is making e substitution. I would judge that w courts would be sympathetic ward a pharmacist who substituted ithout physician approval and who ndertook a legal defense that seeks make the patient responsible for e pharmacist's actions.

educed Prescription Prices?

Substitution advocates are ggesting to the consumer, and par- cularly the consumer activist, that educed prescription prices could llow legalization of substitution. e have seen absolutely no evidence justify this claim. To the contrary, xperience in Alberta, Canada, where ubstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

ROCHE announces new BACTRIM™

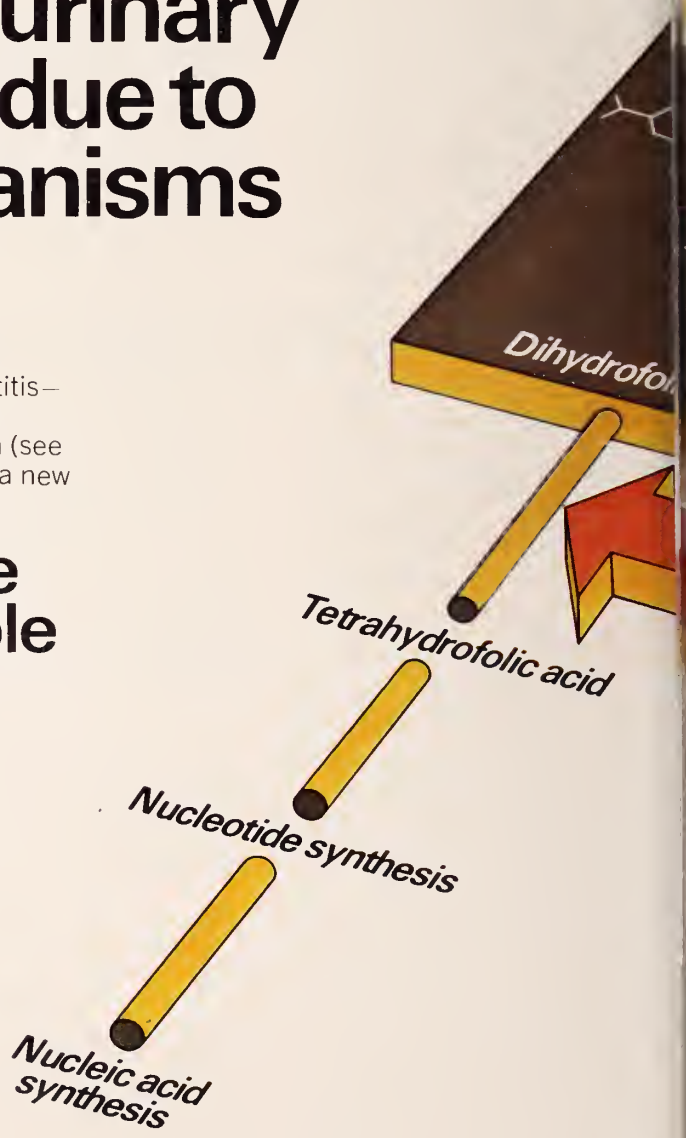
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

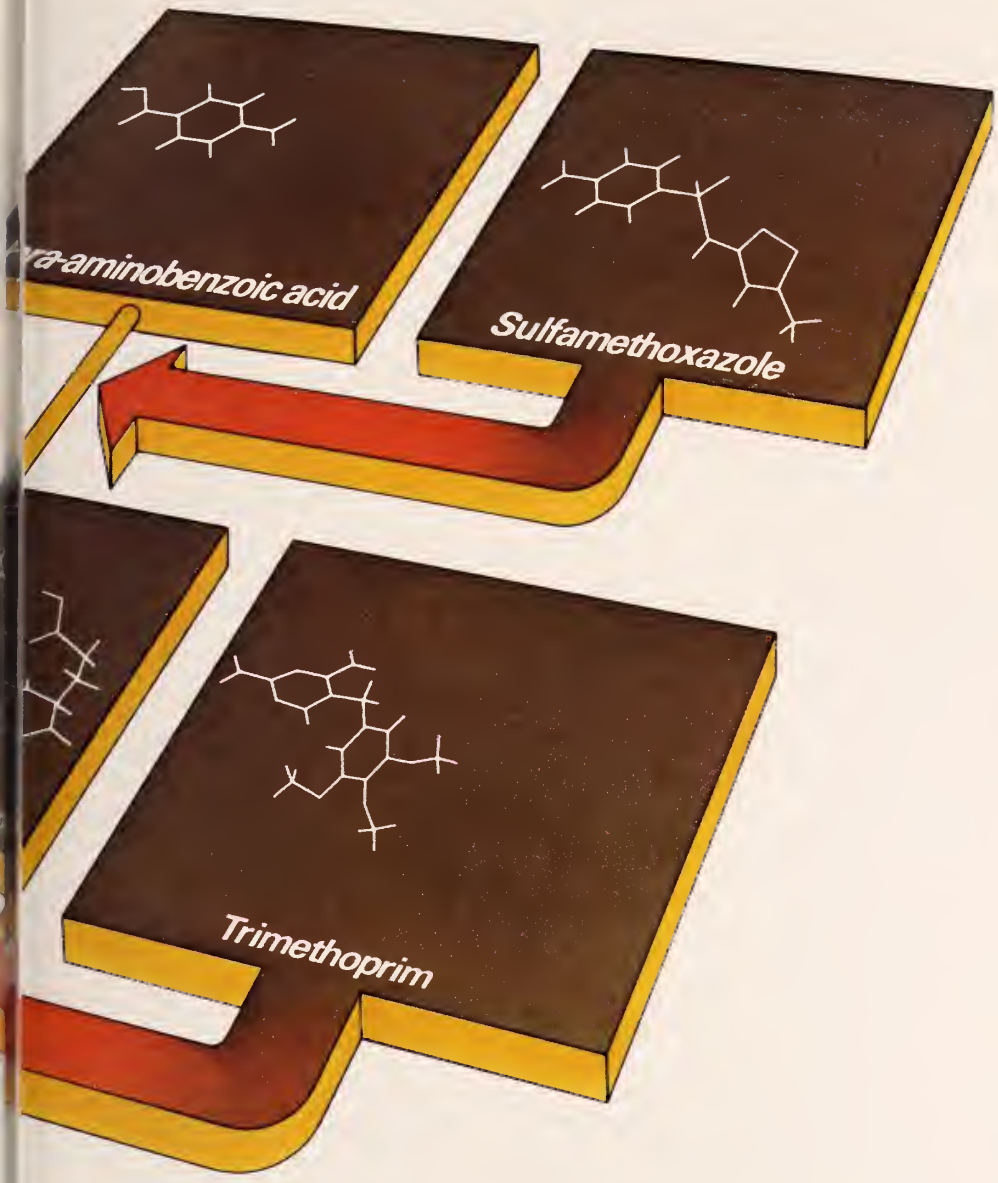
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis – when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





ROCHE

new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

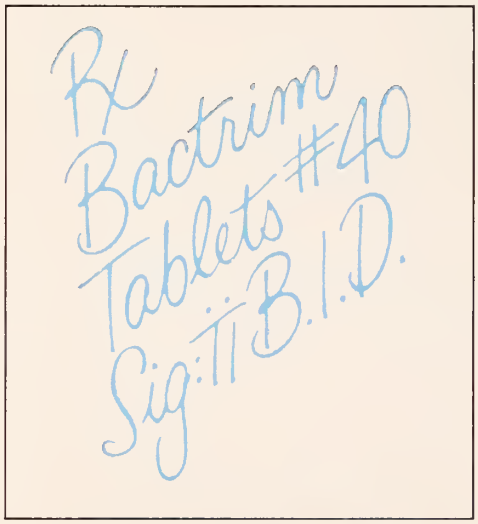
Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

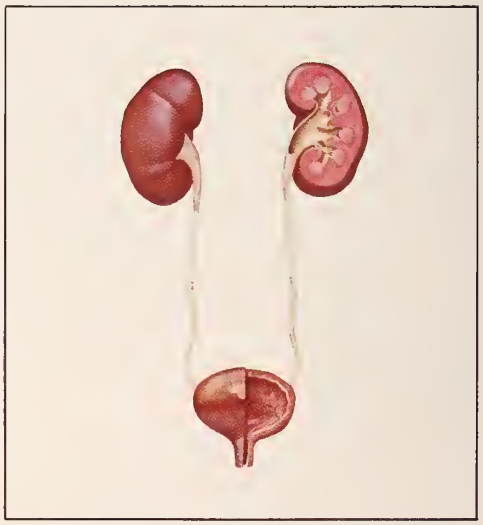
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

RAYMOND HEADLEE MD, Elm Grove—Editorial Director

Medical Enfeoff—as seen by the public

LAST MONTH THE NOTIONS which we as physicians hold about our medical prerogatives were examined. The term "enfeoff" was used merely to compare the strength of some of our assumptions, with the strong sense of "fief" as used in regard to land possession, as an extension of ownership by a King, during the middle ages. Another part of that enfeoffment will now be approached, in fact the assumptions about medical prerogatives made by the public, which may vary from our notions about it.

There is no doubt that our non-medical friends, of all sorts and sizes, give us some special place in their minds. This can be felt in most personal relationships, sometimes even with our families (but not always). At parties, or in mixed gatherings, the physician is often deferred to, or at least referred to, when subjects of general medical content, or needing medical advice, come into focus. This is true, as we all know, regardless of our specialty. Although I've been in psychiatry for thirty years, I'm still asked medical questions by all sorts of persons. Even my mother, who certainly should know better at age 89, still thinks I should have general—and specific—medical information. And of course, we all, generalists and specialists alike, do share a body of physiological and anatomical knowledge which makes us appear knowing in a unique way.

Beyond this, the public tends to treat us with marked ambivalence. The two horns of this dilemma extend far beyond the actual medical knowledge mentioned above, which we are presumed to have. On the one hand, we may be surprised to find that we are treated by the public, *as if* we were both knowledgable and authoratative in areas near or afar from the practice of medicine. Thus we sometimes respond as we are expected to, and tell a Board of Directors what is the best of several political moves for our hospital, or find ourselves responding with advice on PTA problems, or venturing into the tricky waters of child rearing practices, or which is the best investment for safeguarding our hard earned money. The public expects—and we give: over and beyond medical problems. Thus, in this half of their ambivalence toward us, the public enfeoffs us with more than we want, more than we are often qualified to give, and often will not accept our disclaimer, even if we are modestly inclined to offer any disavowal of our general expertise.

This interesting aspect of the public investure of greater knowledge and judgment to the MD leads naturally into the other arm of their ambivalence, namely dislike or actual anger towards physicians. When great expectations are believed, and in part responded to by human beings who practice medicine, then the reaction, when things do not turn out as planned, can be most severe. An extreme form is the malpractice suit, based in form upon some error or fluke of natural healing, but often in fact based upon ill feelings surrounding the error on the mal-healing of some wound or disease. Some students of the phenomena of ambivalence claim that the negative feelings toward doctors come from our "power" of life and death. But really do we, as ourselves, hold that power? Of course not, and the public would fantasy it only if it suited them, but in addition could be encouraged in the kind of fantasy by a physician who was a little too glad to take a role that fit the fantasy. Besides all but the most disturbed persons realize and behave as if the doctor were but another human, joined with him to try to correct flukes of nature. At least they can be made to realize this unless their fantasies are catered to the point that such great expectations are built that they are sure to come crashing down. I'm not referring here to overt promises of cure. We are content to leave that to the chiropractors and other forms of suggestive self-helpers. But the public does have a sometimes grotesque view of doctors as a profession (although often exempting their "own" doctor). These speculations are an attempt to look at some of the factors.

At a broader level, individual doctors, the medical profession, and the medical association in particular, are held responsible, that is enfeoffed with the responsibility for delivery of medical care. Published reports of physicians' incomes are not unheeded, and while it is tempting to justify ourselves via years of study, hours of work, and/or what our same efforts would return to us in industry, the fact remains that the public tends to view us with two complementary, but not at all complimentary, pictures: fat cats and not concerned over social needs. Perhaps our public relations are bad, or perhaps we have thought that we didn't need any; that our good works would be enough; that by our fruits would be known, in the biblical sense. Well, we have the responsibility all right, but the public view of us cannot be dismissed as "wrong." It may be "wrong" by our logic, but by their feelings it exists—and must be taken into account in any planning or thinking that we do. Also careful thought about these matters will show us that direct logic is of no avail, any more than it helped my dentist friend (August editorial) in his problems with fluoride and public. We must simultaneously be aware of the logic and its constant counter pressure from illogic, of the sorts discussed in this series of editorials. Next month, the third aspect of the problems of medical enfeoff—as seen by the body politic, will be discussed. In some curious way, both the professional and the public unconscious attitudes toward medical practice, seem to fuse with the personal convictions of the political person. More on this.—RH

Examination, Certification, and Licensure

THE JULY 23 ISSUE of the *Journal of the American Medical Association* carried a comprehensive description of the present tangle of state *vs* federal, generalist *vs* specialist systems of indicating what can be put under the general rubric: "the practice of medicine." Since we all covet our "right" to practice, this makes us brothers under the . . . . (sensitive) . . . . skin, so far as who shall make this right, and how should it be done. Not every practitioner of medicine in Wisconsin will want to go back and read the entire presentation of this study done by Doctor Hubbard, of and for the National Board of Medical Examiners. But every doctor I've ever known will be vitally interested in the thrust of the report which may well be a map of the coming power struggle for the right to say who shall practice.

The movement seems to be away from the present system of state licensing, so far as the sense of the report is concerned. While the State, which means primarily the State Medical Examining Board, retains the final "legal" acceptance of the right to practice medicine, the trend is toward national systems of examinations and certification, which could be uniformly accepted by each state board for final licensure. Thus the National Board would accept responsibility for examination and licensure at the medical school and intern level, with help from medical school faculties, to prevent overlapping efforts. Then as a man continues to practice, he would be reexamined, perhaps at a specified number of years, by either of two groups. The first group would be the already established specialty boards who are already drawing heavily upon the basic science examinations of the National Board. The second group would be a clinical section of the National Board, designed to test and perhaps repeatedly certify physicians who do not specialize but who rather practice general medicine. The full information from both groups would be available to all State Boards, and would attempt to represent adequate minimal standards for the practice of general and special medicine.

There would be under this system, which may very well come into being, considerable overlap of the individuals responsible for the construction of tests, and of the clinical examinations, of physicians in person and via their office records. However, it is clear to me, at least, that the overlap would be more marked between examiners and academic physicians. In the specialty of psychiatry, for example, the basic examinations are made up by a small group of academicians, who are nonetheless, well known to many of us. For ten years now, I've examined on the clinical section of our American Boards, and I cannot recall more than an occasional nonacademic person who was there. This is not meant as a depreciation of the academic, for I could scarcely feel that way and still continue my sort of professional life. I would like to draw to the reader's attention, however, that the practitioner, without direct academic connection, could very well be a part of any serious attempt to examine, certify, and certainly an essential part in the "judgment" to license, over and beyond formal test capacity, even in the specialties. Only the State Medical Societies can do this.—RH □

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

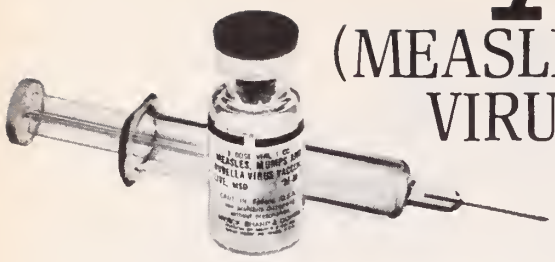
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)



Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝″ needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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LETTERS

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Freshman Preceptor Program

TO: EDITOR—It seemed appropriate to share one small experience relating to the Freshman Preceptor Program completed this summer.

The enclosed (below) is an entry from the diary kept by my student as we shared our time this summer. I believe there is a message for all of us here.

G. J. DERUS, MD
Madison, Wisconsin

Met Doctor ——— at a coronary conference this morning. Our baseball game was rained out last night.

It was Doctor ———'s day off, so I got to be on my own for the rest of the day. (Dr. ———'s partner is still out of town on vacation.) Rita is really going downhill fast, and I took the opportunity to visit her for 3½ hours this morning. She couldn't even talk well, she's so weak, and she never did say much. I just sat by her bed and held her arm. She was breathing rapidly and shallowly since she is spinning down in congestive heart failure. It is hard to just sit there because you want to be able to do something, but there isn't anything that can be done. Doctor ——— is heavily diuresing her to empty her lungs, digitalizing her for her heart, and letting her breathe O_2—all to try and help her in breathing.

Rita has a sister and brother who take shifts round the clock being with her and helping feed her when she can eat something. I met both today and got to talk really well with them. They're normal people and feel frustrated and sad at losing their sister. This experience makes me feel really strongly about appreciating health and all the little things one gets to take for granted. She probably won't get to be outside again, and this is *really* sad! This is why I "grab for all the gusto" I can and celebrate life on the weekends so much. And I'm aiming for a life where I'm not just living for the weekends, but rather where every day is integrated around Lynn and me and our family and has meaning. I don't want to feel rushed through life, but rather to feel that I've lived a long time when I die and that I've experienced the seasons and nature and relationships with other people very meaningfully. I don't want to wonder where all the years went, because I'll know where they went! It might take setting up a practice at home to integrate family life and doctor's life to my satisfaction. We'll have to see . . . . B.C. □

Shown above is one of the card selections

A. CHRISTMAS AT OLD FORT CRAWFORD MILITARY HOSPITAL—Dry point etching with pastels of the restored military hospital at Old Fort Crawford, Prairie du Chien, site of CESF medical museum. Inside 5"x7" card description tells of museum and fort opposite greeting: "Merry Christmas and Best Wishes for the New Year."

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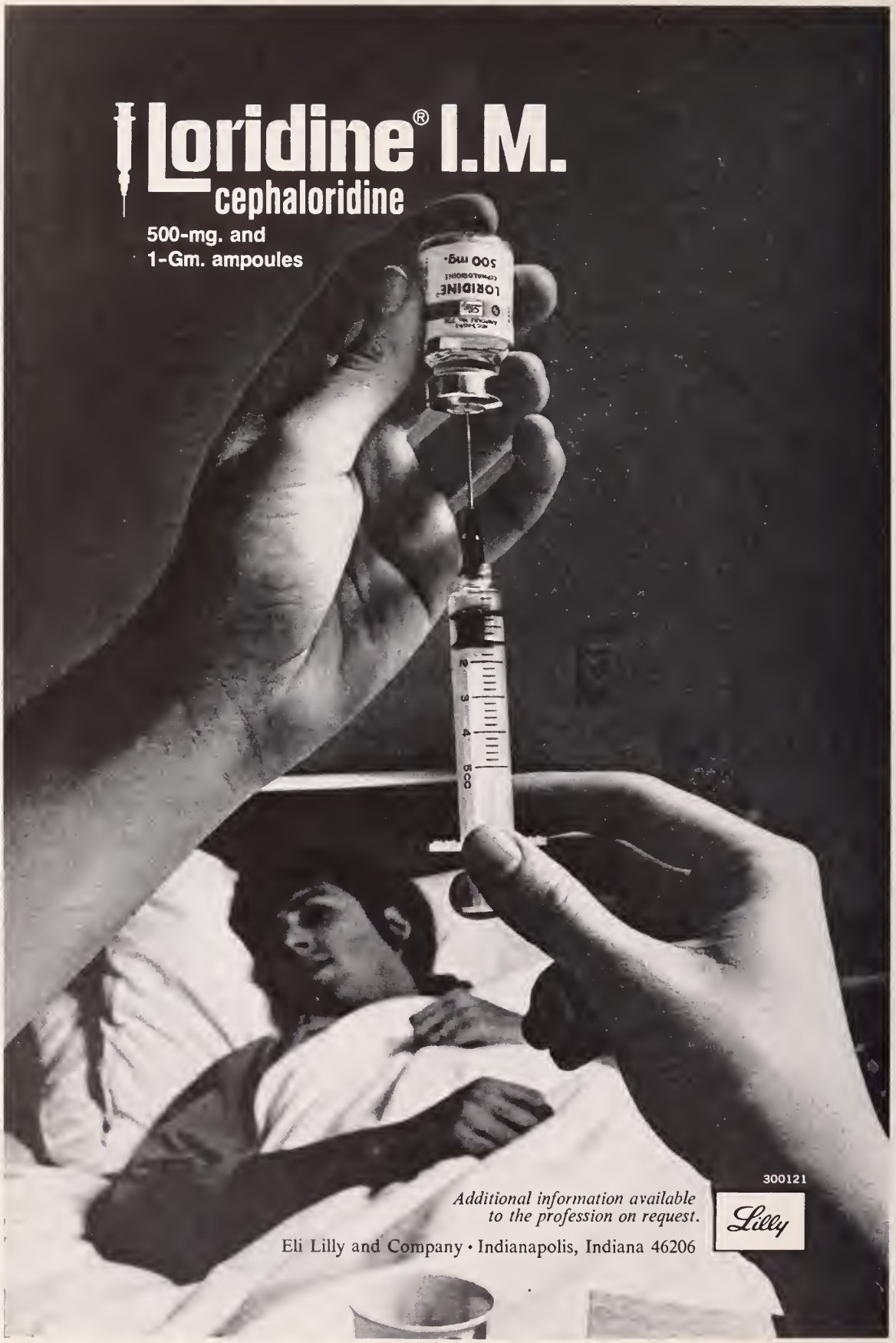
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WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 10 OCTOBER 1973

Snowblower Injuries of the Hand

GEORGE L. LUCAS, MD
Madison, Wisconsin

MAN'S EFFORTS TO RELIEVE himself from physical labor usually complicate his life by virtue of the ever constant danger from "labor-saving" machinery —witness the constant toll of injuries inflicted by automobiles, cornpickers, lawn mowers, and a wide variety of industrial machinery. Unfortunately, the hand is frequently the body member devastated by machinery.

A fairly recent innovation, the snowblower, has become a particular hazard for fingers, and this has made the snowblower a somewhat less than ideal solution to the odious task of wintertime snow shovelling. The snowblower is basically a gasoline-powered tractor which is equipped with a fairly slow moving, auger-like scraper blade which pushes and pulls snow off the pavement and directs it into a large receptacle or housing. In this housing, the snow is then rapidly forced out of the machinery by means of a rapidly revolving fan-like impeller blade. The snow is then forcibly propelled out a discharge chute and thrown to the side of the area to be cleared (Fig 1).

There are several safety features of the snowblower designed to prevent injury, including shielding the rotor and scraper blade, clutch mechanisms which must be engaged before the rotor or fan will operate, and enclosure of the fan or impeller blade in a housing as well as providing a deep chute for directing the thrown snow. Unfortunately, if the snow can be forced out of the chute, a hand can also be placed into the chute and thus dangerously close to the fast moving impeller blade. All of the 10 patients whom I have treated for snowblower injuries during the past two winters have been injured by the impeller blade and none by the more lethal-appearing scraper blade.

Figure 1—Illustration of typical snowblower with auger type scraper blades and snow propeller chute demonstrated.

One can usually predict that patients with snowblower injuries will be arriving in the hospital emergency room by the type of snow which is falling. The snowblower works quite well for light, dry snow, but with the wet heavy snow the chute frequently becomes clogged. In a hasty move the operator reaches into the chute to unclog the channel and occasionally reaches too far and sustains digital injury. All of the patients I have attended have been injured in such types of snow falls, usually occurring early in winter or in March near the end of our snow season.

Since the rapidly revolving fan blade imparts the damage to the distal portion of the involved hand, injuries produced by snowblowers are almost entirely digital injuries. These injuries are largely lacerating or contusing injuries and are usually not complicated

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by much crushing, tearing, or shredding of tissue as is encountered in other machines such as the cornpicker. Multiple digits are usually involved so that the 10 patients in this series provided a total of 23 digital injuries. A variety of digital injuries produced in the 10 patients reported here is summarized in Table 1. Primary amputation of the finger tip, tendon laceration (extensor and flexor), nerve laceration or contusion, joint disruption or fracture, in addition to skin and soft tissue disruption, may all occur. Fortunately the lacerating or contusing effects of the fan blade in the absence of more unfavorable tissue damage allows one to be fairly vigorous in the repair of these digits. Additionally, contamination, except for snow and glove material, is less than in many types of open hand injuries; and the propensity for establishment of bacterial infection is somewhat minimized, thus providing still further impetus for primary repair of damaged tissues. In only one patient (No. 3) did the development of sepsis cause devitalization of a finger tip and require secondary amputation. However, antibiotic administration (intravenous penicillin or synthetic penicillin initially) plus tetanus prophylaxis is an important part of the patient's initial therapy in addition to wound care, debridement, and judicious closure.

In three fingers a primary finger tip amputation had occurred. In one patient (No. 8) amputation of two finger tips was tidy and allowed repair by Kutler flap advancement and full thickness grafting (Fig 2). One other patient (No. 7), an octogenarian, amputated his finger cleanly, but walked around for nearly 12 hours with his hand in his glove. The finger was treated by simple bony shortening and soft tissue revision. He developed a very minor postoperative wound infection which cleared rapidly. A third patient who required amputation (No. 6) had such a severely damaged ring finger that primary proximal amputation with flap closure was carried out (Fig 3). A further patient (No. 2) actually lost a small amount of distal tuft osseous tissue but was more appropriately treated by cross-finger flap for volar pulp loss (Fig 4). It is obvious

Figure 2—Circumferential laceration, index finger, with distal amputation; amputation distal segment, middle finger.

Figure 3—Segmental lacerations, middle and ring finger, with obvious deformity in posture due to fracturing of phalanges.

Figure 4—Volar pulp loss, middle finger, and laceration, index finger at segmental levels.

TABLE 1—*Digital injuries*

Patient	No. of Fingers	Type of Laceration	Amputation	Nerve Injury	Tendon Injury	Bone Injury	Joint Injury
No. 1 Housewife	Index, middle ring	Puncture dorsum middle	0	0	Extensor middle finger	Proximal phalanx index, middle, ring; middle phalanx, middle and ring	0
No. 2 Minister	Thumb, index	75% circumferential thumb, nail avulsion index	0	Radial digital thumb	0	Distal phalanx thumb, tuft fracture index	0
No. 3 Draftsman	Index, middle	Circumferential index 100%	Index and middle	0	Extensor and profundus index	Middle phalanx + 2 amputations	DIP index
No. 4 Retired Factory Worker	Index	First web space	Index	0	0	Amputation	0
No. 5 Policeman	Index, middle, ring	Distal phalanx index, distal and middle phalanx middle, distal phalanx and PIP joint level ring	Surgical at proximal phalanx ring	Radial digital N middle, ulnar digital N ring	Central sup. and profundus middle, sublimus and extensor ring	Middle phalanx middle, distal and middle phalanx middle	PIP dislocation middle and index, DIP location ring
No. 6 Retired	Index, middle, ring	DIP joint index, middle phalanx middle and ring	0	0	0	Middle phalanx middle finger	0
No. 7 Teacher	Middle, ring	Dorsum DIP joint both fingers	Secondary ring finger	0	Extensor both fingers	Distal phalanx ring	Dislocation DIP middle, laceration DIP ring
No. 8 Student	Index and middle	DIP and PIP joint level index, volar pulp loss middle	Terminal tuft middle	0	0	Distal and middle phalanx, index and middle	Laceration PIP index, laceration DIP middle
No. 9 Developer	Index, middle ring	DIP level on fingers, middle phalanx middle and ring	0	Contusion on 3 fingers	Sublimus middle, extensor ring	Distal phalanx index, middle	
No. 10 Feed and Grain Dealer	Middle and ring	80% circumferential DIP middle	0	Radial middle	Profundus and extensor middle	Distal phalanx both fingers	Laceration DIP Middle

from consideration of the varying types of amputation alone which are encountered, that the surgeon treating snowblower injuries must be well versed in all possible methods of dealing with an amputated digit.

Tendon injury occurred in several instances (Table 1). Fifteen tendons—both flexors and extensors—were injured in 6 of the 10 patients, although four of the tendons were only partially lacerated. Additional injury to tendon sheaths occurred in other patients. The patients with partial tendon lacerations all gained a satisfactory degree of joint motion but none regained full motion. The patients' tendon injuries were all at/or distal to the proximal

Figure 5a—Preoperative photograph demonstrating fracture of the proximal phalanx of the index, middle and ring finger; middle phalanx of the middle and ring finger.

Figure 5b—Postoperative photograph demonstrating Kirschner wire fixation of multiple phalangeal fractures.

interphalangeal joint, and all patients who sustained complete extensor transection at this level achieved some active extension. The flexor tendon injuries, with the exception of a sublimus completely transected in the finger requiring primary amputation, were all partial and have responded well to simple suture technics. The impairment in joint motion in many of these fingers is due also to direct joint injury, particularly fibrosis secondary to scarring or skin contracture, so that precise comparison between these results and other reported results of digital tendon injury is not meaningful.

Several of the fingers seen in this series were the site of multiple or segmental lacerations, thus imparting the potential for digital nerve injury at several levels along the finger (Fig 3). Clinical examination will frequently suggest digital nerve injury, and exploration of the digital nerve at each level of skin laceration becomes mandatory. Surprisingly, examination in the depths of the various lacerations often disclosed a contused but anatomically intact nerve so that direct nerve suture was required in only two fingers. Unfortunately, the damage to the nerve precluded suture in three other fingers. In one of these hands (No. 6), laceration of the nerve as well as tendon, joint disruption, flexor and extensor tendon injury, plus severe skin damage, influenced my decision to amputate primarily. An irreparable radial digital nerve injury in this patient's adjacent finger is the source of considerable difficulty due to sensory loss and a superficial volar neuroma. The third digit with irreparable nerve loss, a thumb, has been reinnervated almost completely from the opposite-sided distal nerve and is not troublesome.

The infrequency of digital nerve injury is even more surprising when one considers the high occurrence of bone and joint injury in this series. Twenty-

three fractures, including terminal amputations, are recorded in this series. All but one occurred in the middle or distal phalanges. One patient (No. 10) sustained five phalangeal fractures of three fingers. All fractures were closed except for two small puncture wounds. Her salvation from open injury came from heavy leather mittens (Fig 5). Because wet snow occurs during relatively warm winter weather, most people operating the snowblower are not afforded this protection as they wear only light gloves. One additional non-displaced middle phalangeal fracture occurred in a man (No. 4) with a severe circumferential laceration of the adjacent digit.

Internal fixation in the form of fine Kirschner wires was used in nearly all instances and union has occurred in all phalanges. No pin tract infection or osteomyelitis has occurred. It is felt that use of pin fixation will allow very early motion and thus joint mobility can be regained. This has been true in nearly all cases except for two patients. Patient No. 10, with multiple phalangeal fractures, had considerable contusion of her hand and soft tissue injury at the digits despite the absence of open wounding and has developed a pseudoboutonniere deformity in the middle and ring fingers. Patient No. 1 developed a digital interphalangeal joint extension contracture due to extensor adherence over the ring finger, middle phalanx. Considerable improvement was noted following extensor tenolysis, but he has gradually lost much of the regained motion over the past few months.

Open injury occurred in nine joints. Frank dislocation was noted in three of these patients. These injuries were accompanied by tendon injury as well as capsular and ligamentous injury. Treatment consisted of tendon repair and skin suture without attempts at capsular repair with Kirschner wire stabilization in one joint. No instability has resulted in either of the dislocated or lacerated joints, although limitation of motion is a problem in nearly all of these fingers. Fortunately, distal joint impairment was compensated in some degree at proximal joints so that functional impairment from partial joint ankylosis was not great in this group of patients.

Skin lacerations are often multiple and extensive and in five instances were nearly completely circumferential. A left-handed architect sustained a complete circumferential laceration at the middle phalangeal level as well as complete finger tip amputation of that finger and the adjacent finger. Fortunately, neurovascular bundles were spared and circulation was adequate enough to support a full thickness graft as treatment for the amputated finger tip (Fig 2).

As with all types of machinery injuries, the best treatment is prevention. Undoubtedly the snowblower could be made safer, but presumably such a safety move would be at the expense of marketability of the equipment and it is, therefore, unlikely that this step will occur. Thus, it becomes a matter of public education as to the dangers of the snowblower, and this could certainly be stressed in the advertising for snowblowers at the time they are sold. Despite any such campaigns of education, there will remain those accident prone and careless people who continue to suffer such injuries.

As indicated previously, primary treatment can be cautiously vigorous because of the lack of severe shredding or crushing of tissues and because of the somewhat lessened potential for early sepsis in these injuries. Nonetheless, the wound should be managed by well-known technics of cleansing and exposure under adequate conditions of anesthesia. Because of the multiplicity of tissues disrupted, it is almost always preferable to take these patients to the operating room and operate under either reliable regional anesthetic technics or general anesthesia. The wounds do not require extensive debridement, but debridement must be adequate and must include all foreign material. Frequently paint from the blades is found embedded in the bone and filling material from gloves is also a frequent contaminant which must be completely removed. The lacerations must be explored in an effort to determine presence or absence of digital nerve or tendon injury. My preference for skin suture of these wounds is to use fine non-absorable sutures sparingly placed. Amputations require, as indicated, a variety of approaches including Kutler type flap repair, standard amputation revision with flaps, full thickness grafting, or cross-finger flap coverage. The fractures almost always require stabilization with Kirschner wires, thus allowing early attempts at mobilization of the adjacent joints. No difficulties have been encountered with the use of these wires. It is also occasionally necessary to stabilize a joint which has been the site of dislocation and laceration of the supporting structures.

Tendon repair need not be complicated and in the presence of other injuries is best done by simple suture, rather than attempts at pull-out wire or barbed tendon suture. Fortunately, these injuries are fairly well distal and the problem of digital sheath encroachment on a tendon repair does not occur. Despite good healing of the tendon, joint limitation is to be expected because of the combination of injuries, and obviously one cannot expect tendon function to approach that which might be seen following a clean knife or glass laceration.

Digital nerves are frequently contused but fortunately not very often lacerated. They occasionally are lacerated in such a way that surgical repair cannot be carried out, but again because of the distal location crossover may occur onto the pulp space and satisfactory functioning may be seen following a nerve injury. It remains, however, critically important to examine the depths of all lacerations to assess the status of the nerve.

Summary

The snowblower is a labor-saving device which has a peculiar potential for digital injury. The patients who sustain such injury are unlikely to be candidates for primary amputation of a damaged digit, and rather attention should be focused at primary repair of damaged structures rather than proximal amputation. A fairly good degree of success will be obtained if cautious optimism is expressed in an attitude of restrained vigor in applying sound surgical principles for repair of the various tissues as they are encountered. □

Routine Operative Cholangiography:

Analysis of 506 Consecutive Cholecystectomies

EDWARD C SALTZSTEIN, MD; SUBBARAO V EVANI, MD; and ROBERT W MANN, MD, Milwaukee, Wis: *Arch Surg*: 107:289-291 (Aug) 1973

Transcystic duct operative cholangiography was performed in 423 of 506 consecutive cholecystectomies. Patients were classified prospectively as having or not having a preoperative clinical indication for common duct exploration on the basis of jaundice, pancreatitis, or an elevated alkaline phosphatase. Cholangiography avoids consideration of classical intraoperative indications for common duct exploration.

Thirty-nine of 79 patients, or 50%, with positive preoperative clinical indications for common duct exploration had normal cholangiograms, and were spared exploration of the common duct by operative cholangiography. Of 427 patients without clinical indications for duct exploration, unsuspected common duct stones were demonstrated in eight, or 1.8%. Routine operative cholangiography reduced the number of common duct explorations to 11.1% of cholecystectomies, and reduced negative common duct explorations to 3.2%.

This experience suggests that the indication for operative cholangiography is "cholecystectomy." □

Duodenal Wall Tumors and the Zollinger-Ellison Syndrome

Surgical Management

JAMES W HOFMANN, MD; PAUL S FOX, MD; and STUART D WILSON, MD, Milwaukee, Wis: *Arch Surg* 107:334-339 (Aug) 1973

Surgical management of patients with islet cell duodenal wall tumors (DWT) and the Zollinger-Ellison syndrome (ZES) is controversial. Complete tumor excision or total gastrectomy have been advocated. Duodenal wall tumors were identified in 13% (103 of 800) of patients in the Z-E Tumor Registry.

The characteristics of ZES patients with DWTs and results of surgery were studied. Less than half of the patients with DWTs had solitary lesions. Four subgroups were identified: group 1, 48 patients with localized DWTs; group 2, 26 patients with DWTs and lymph node metastasis; group 3, 24 patients with duodenal wall and pancreatic tumors; and group 4, 5 patients with DWTs and islet-cell hyperplasia.

Total gastrectomy resulted in the best survival when the DWTs were associated with pancreatic or metastatic lesions or both. Attempts at local tumor excision resulted in a 51% ulcer recurrence rate. Local excision of DWTs with less than total gastrectomy was successful in only 20 patients.

Successful surgical management depends on the surgeon's ability to identify those patients with multiple tumor sites. □

Gram-negative Pneumonia

JUNE DeBOER UNGER, MD, HAROLD D ROSE, MD, and GEORGE F UNGER, MD, VA Hospital, Wood, Wis: *Radiology* 107:283-291 (May) 1973

The chest roentgenograms of 58 cases of pneumonia due to Gram-negative organisms were reviewed. Of these, 19 were caused by *Pseudomonas aeruginosa*, 15 by *Klebsiella*, 7 each by *Enterobacter* and *Escherichia coli*, 8 by *Proteus* and 2 by *Bacteroides*. *Pseudomonas* pneumonia was characteristically alveolar in distribution with rapid progression to extensive macrocavitation. Massive lobar consolidation occasionally accompanied by huge lung abscesses and voluminous inflammatory exudate was seen in a minority of the Klebsiella cases but considered typical when present.

Bacteroides was characterized by massive empyema and lobar consolidation. The remaining pathogens failed to provide any specific roentgenographic features. □

Human Kidney Preservation and Shipping

H MYRON KAUFFMAN, JR, MD; RICHARD E RODGERS, MD; WILLIAM S GROSS, MD; BRADLEY M SHREFFLER; PETER IVANOVICH, MD; FREDERICK K MERKEL, MD; JOHN J BERGAN, MD and THOMAS C MORE, MD, Milwaukee County General Hospital, Milwaukee, Wis: *Transplantation* 15:465-468 (May) 1973

Recent demonstrations of the feasibility of a national organ-sharing network places a premium on reliable and reproducible means of organ preservation. At the present time, there are basically two methods of preserving cadaveric kidneys. The first, continuous pulsatile perfusion, involves taking the continuous perfusion apparatus to the site of organ harvesting and transporting the kidneys while they are being perfused on the machine. Although it is somewhat cumbersome to use a 700-pound machine to transport kidneys, its efficiency has been clearly demonstrated. The second method involves surface cooling and/or flushing the kidney with an extracellular or intracellular fluid. The reliability of this method, for periods of time under 15 hours, also has been demonstrated.

Twenty-four consecutive human cadaveric kidneys were preserved by a combination of both extracellular fluid flush and by continuous pulsatile perfusion by three separate transplant centers. One kidney underwent hyperacute rejection and was immediately removed. Effectiveness of preservation could not be evaluated for this kidney. Each of the remaining 23 kidneys eventually achieved satisfactory function, although four underwent varying temporary degrees of acute renal insufficiency. Twenty of these 23 kidneys produced over 1000 ml of urine during the first 24 hours following transplantation.

Three kidneys underwent two periods of continuous pulsatile perfusion, the first being at the center harvesting the kidney, and the second being at the center transplanting the kidney. The combined preservation times for these three kidneys were 30, 41, and 69 hours respectively and they all functioned promptly and made over 1000 ml of urine during the first 24 hours. The 69-hour kidney is the longest reported preservation of a human kidney that has had satisfactory function. Advantages of both methods of preservation complement each other and should be exploited in organ sharing. □

Colposcopic Diagnosis of Cervical Neoplasia

ADOLF STAFL, MD, and R F MATTINGLY, MD, Medical College of Wisconsin, Milwaukee, Wis: *Obstet Gynecol* 41:168–176 (Feb) 1973

The practical value and diagnostic accuracy of colposcopy was evaluated on 1410 patients with abnormal cytology or grossly suspicious colposcopic lesions referred to satellite colposcopic clinics which were established in strategic locations throughout the State of Wisconsin.

A focal colposcopic lesion was found in 659 patients (46.8%) and in all these patients directed biopsy was taken. The directed biopsy alone revealed 252 cases of mild to moderate dysplasia, 93 cases of severe dysplasia, 133 carcinoma *in situ,* 5 microcarcinoma, and 16 invasive cancer. The definite surgery specimens confirmed the histologic accuracy of the directed biopsy in all but 2 patients.

The recognized false negative rate of directed biopsy in this study (more than one histologic degree greater in the surgical specimen than the directed biopsy) was 2 cases in 659 patients (0.3%). In 226 cases of severe dysplasia or carcinoma *in situ* diagnosed by directed biopsy, diagnostic conization was required in only 8 cases where the lesion extended into the endocervical canal. In 218 patients, definite therapy was performed without the need of diagnostic cervical conization. The definite surgical specimen revealed no instance of invasive carcinoma.

In patients with histologically proven carcinoma *in situ,* the referring cytology was atypical in 21.2% of the cases. The cytologic interpretation of the vaginal smear in these cases was that of inflammatory atypia; however, carcinoma *in situ* was diagnosed on the initial colposcopic examination by the identification and directed biopsy of a focal colposcopic lesion. Eighty-nine pregnant patients with abnormal cytology were referred for colposcopic consultation and diagnostic conization was avoided in all of them. In 25 patients with severe dysplasia or carcinoma *in situ* diagnosed by directed biopsy during pregnancy, definite surgical treatment was postponed until after the puerperium without advancement of the disease. The study emphasizes the importance of regional colposcopic centers for maximum clinical utilization, diagnostic accuracy, and clinical teaching. □

Snowmobile Injuries in Northern Wisconsin

GEORGE F. PRATT, MD
Rhinelander, Wisconsin

During the last 12 years, use of the snowmobile as a recreational vehicle has steadily increased so that in 1973 there are about 180,000 snowmobiles registered in Wisconsin. Accompanying this increase has been a large number of accidents, some leading to prolonged disability or death.

This study is made to expose the dangers and to analyze as far as possible the circumstances surrounding injury. I believe we have a responsibility to set forth the seriousness of the problem and to suggest ways in which injury can be prevented.

Other investigators have reported on this subject, but it is felt that in this state alone there are a huge number of unreported accidents.

Materials and Methods

We did not start cataloging these injuries until 1969, although we were able to find 16 cases from earlier years. The total number of cases studied is 375, taken from the files of St. Mary's Hospital, Rhinelander, Wisconsin, and the information herein presented is gained from a study of these charts.

Results

Table 1 shows the yearly number of injuries which increased through the 1970-71 season and then declined. We think this decline may have resulted from the unfavorable snow conditions for snowmobiling during the latter part of the 1971-72 season.

Table 2 shows that about 30% of the injuries were serious enough to require hospitalization although among those treated as outpatients, there were a number of injuries that caused loss of time from school or work.

Table 3 indicates that 35% of the injuries occurred after dark. In this region a large number of night riders are engaged in bar-hopping; and although the role of alcohol in accidents is debated, I would estimate that at least 80% of those injured after dark have imbibed enough alcohol to impair judgment.

Table 4 shows that nearly 80% of those injured were males.

Table 5 indicates the wide age distribution with the peak incidence at age 21-30. Seventy-one children (19%) below age of 16 (the age limit for driving an automobile) were injured.

Table 6 is an attempt to classify the mechanisms of injury. Thirty percent ran into something while another 29% were thrown off or had tipped over. Fifteen percent were injured by being struck by another snowmobile which illustrates the crowding that is now taking place. Mechanical failures comprise about 7% of the total and are elaborated in Table 7. Although small in number, the clutch explosions and the stuck throttles have had lethal consequences. A child was killed by a clutch explosion near Three Lakes, Wisconsin, and a spectator was killed by a stuck throttle and runaway machine near Eagle River, Wisconsin, in the 1971-72 season. If an extremity or clothing is caught in the track, serious soft tissue, nerve and multiple bone injury has occurred.

Table 8 shows the frequency of injury to various parts of the body, none of which is immune from damage. The lower extremity leads with 41%, with head and upper extremity following with 23% each. Last is the trunk with 13% of the injuries.

Table 9 shows the various types of injury. Interesting, at 30%, fractures are the most common injury with almost every bone in the body represented. Lacerations were most common in the head and lower extremity. Visceral injuries were generally severe and included puncture of the lung with pneumothorax and rupture of the spleen.

Table 10 gives the hospital days for the last four seasons. The total is 891 days and the yearly average is 223 days. We do not have figures for days lost from school or work, but they would obviously be greater than the number of hospital days.

Table 11[1] lists the number of snowmobile deaths in Wisconsin for the last four years. About 64% of the 58 deaths were caused by injury to the head and neck, 15% were caused by drowning, and 12% were due to visceral injury. It is interesting that 31% of the deaths were caused by striking a car or truck, showing the danger of operating the snowmobile on or near roads. It is also interesting that 83% of victims were male which is in about the same ratio as in the accidents. About 31, or 53.5% of the victims, were killed after dark.

Table 12 is a catalog of all the injuries described in this study.

Reprint requests to: George F. Pratt, MD, The W. S. Bump Medical Group, SC, 1020 Kabel Ave., Rhinelander, Wis. 54501.
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TABLE 1
Cases by year

	No.
1966-1968	16
1968-1969	83
1969-1970	88
1970-1971	113
1971-1972	75
TOTAL	375

TABLE 2

	No.	%
Hospitalized	113	30
Outpatient	262	70
TOTAL	375	100

TABLE 3
*Time of accident**

	No.	
Daylight	175	
Darkness	97	(35%)
Unknown	4	
TOTAL	276	

*Computed over last three years only

TABLE 4
*Sex**

	No.	%
Male	213	78
Female	63	22
TOTAL	276	100

*Computed over last three years only

TABLE 5
Age

	No.
0-10	21
11-15	50
16-20	60
21-30	97
31-40	79
41-50	38
51-60	24
61-70	6
TOTAL	375

TABLE 6
Cause of injury

	No.	%
Struck object	114	30
Thrown, fell off, tipped over	110	29
Struck by another snowmobile	56	15
Unknown	41	11
Mechanical failure	27	7
Manipulating machine	13	4
Frostbite, unprotected skin, eyes	11	3
Going too fast	3	1
TOTAL	375	100

TABLE 7
Injuries due to mechanical failure

	No.
Track injuries	9
Clutch blew up	5
Throttle stuck	5
Cut into knee from unprotected clutch	3
Gas spilled	2
Belt whip	1
Clothing caught in clutch	1
Ski broken off	1
TOTAL	27

TABLE 8
Part of body injured

	No.	%
Lower extremity	182	41.5
Upper extremity	100	22.7
Head	99	22.6
Trunk	58	13.2
TOTAL	439	100.0

TABLE 9
Type of injury

	No.	%
Fractures	124	28.2
Lacerations	114	26.0
Contusions	111	25.3
Sprains	35	8.0
Cerebral concussion	17	3.9
Abrasions	13	2.9
Visceral	9	2.1
Dislocations	8	1.8
Eye foreign body	6	1.4
Vascular	1	0.2
Nerve	1	0.2
TOTAL	439	100.0

TABLE 10
Hospital days

	No.
1968-1969	188
1969-1970	145
1970-1971	370
1971-1972	188
TOTAL	891
Average per year	223

TABLE 11
Snowmobile deaths in Wisconsin

	No.
1968-1969	10
1969-1970	7
1970-1971	13
1971-1972	28
TOTAL	58

TABLE 12
All injuries

	No.
Fractures	124
Skull or face	11
Clavicle	11
Humerus	5
Forearm	17
Carpal	1
Metacarpal	4
Phalanges	6
Sternum	1
Pelvis	1
Femur	4
Patela	3
Tibia and fibula	18
Tibia	7
Fibula	5
Malleolar	8
Tarsal	2
Metatarsal	4
Spine	10
Ribs	6
Sprains	35
Upper extremity	2
Shoulder	3
Knee	13
Ankle	7
Foot	2
Back	8
Frostbite	11
Cerebral concussion	17
Contusions	111
Trunk	20
Upper extremity	24
Lower extremity	56
Head	11
Lacerations	114
Trunk	2
Head and face	52
Upper extremity	15
Lower extremity into knee joint	5
Other	40
Abrasions	13
Head	2
Upper extremity	3
Lower extremity	8
Dislocations	8
Metacarpophalangeal joint	1
Elbow	1
Achromioclavicular	4
Shoulder	2
Visceral	9
Burns	1
Vascular	1
Peripheral nerve	1
Gasoline conjunctivitis	6
TOTAL	451

Discussion

The first step in preventing snowmobile accidents is to realize that danger is present. The 375 injuries and 58 deaths reported in slightly more than four years is evidence enough of danger.

We are not alone in emphasizing the roles of alcohol and darkness in causing accidents. In a series reported from the Duluth region[2], alcohol was implicated in 40% of injuries and in a New Hampshire series,[3] 57% of injuries occurred after dark. In studying injuries near Marshfield, Wisconsin,[4] investigators noted that snowmobiling farmers circling in their familiar fields became disoriented in the dark and struck their own barbed wire fences.

In this state, 16 years is thought to be a reasonable age to start driving automobiles or motorcycles. Since the snowmobile appears to require comparable judgment and skill for operation, it is felt that 16 would be a more reasonable age than 12 or less which is now Wisconsin law. Nineteen percent of our injuries were children under 16 years of age.

Being thrown off or striking an object, the cause of about 60% of the injuries, would appear to result from failure to adjust speed and control of the vehicle to the terrain. Failure to maintain proper trail interval is one cause of being struck by a snowmobile.

Peters et al[5] found that in their series, only one-fourth of the victims had protective clothing such as a helmet, snowmobile suit, and boots. Daniel[6] advises a well-made helmet with a face mask and visor such as worn by Grand Prix racers. It is thought that adequate protection would prevent certain injuries, especially those occurring at low speeds.

Chism and Soule[7] reported 15 of 103 injuries were compression fractures of the lumbar spine, mainly from jumping with the driver seated. To prevent this injury, they advise a posting (weight on feet) position for the driver.

There is among many snowmobilers a drive to have the fastest machine and to avoid being passed by another. Slower trail riders in a group have a fear of being left behind and are tempted to drive faster than their capability allows.

Regulation of snowmobiling is slow in coming and enforcing laws is difficult because of the necessity for officers to patrol vast areas.

Summary

An analysis of 375 snowmobile injuries seen in one hospital is presented. Those who engage in this pastime are subjecting themselves to the danger of injury and death.

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Pseudomonas Aeruginosa Pneumonia in Adults

H. D. ROSE, MD, M. G. HECKMAN, MD, and J. D. UNGER, MD, Wood VA Center, Milwaukee, Wis: *Am Rev Resp Dis* 107:416-422 (March) 1973

Common gram-negative bacilli were the causative agents in 59 (7.28%) of 801 patients with pneumonia seen at a large general hospital during a 4-year period. In 19 of these patients, the infection was caused by *Pseudomonas aeruginosa;* in 16, by *Klebsiella,* 8 by *Proteus,* 7 by *Enterobacter,* 7 by *E. coli,* and 2 by *Bacteroides.* The 19 patients with pseudomonas pneumonia were studied in more detail. These patients were elderly, and most had severe obstructive lung disease or had recently undergone an emergency surgical procedure. Prior multiple or broad spectrum antimicrobial drug therapy was usual. The infection was precipitated by aspiration and appeared on chest roentgenograms as an alveolar infiltrate with cavitation. Multilobar involvement that included a lower lobe was characteristic. Pseudomonas pneumonia was a terminal illness in 18 patients, but vigorous attention to tracheobronchial toilet and improved antimicrobial drug therapy should decrease the mortality of this infection. □

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FROM SPRING MEETING—MADISON, JUNE 1-2, 1973

Edited by Gastone G. Celesia, MD, Vice-President

Paroxysmal Symptoms in Multiple Sclerosis

Charles Miley, MD, Madison

Two cases of multiple sclerosis (MS) with paroxysmal neurological disturbances, manifested by difficulty with speech and locomotion, were described. Similar cases have been described previously under the heading of paroxysmal dysarthria and ataxia. There are a variety of other paroxysmal symptoms that have been reported in MS which were discussed in this paper. These can be distinguished from the ordinary, transient disturbances which are known to occur in MS by their explosive, repetitive occurrence, and by their localization to the brainstem or cervical cord. The mechanism by which these attacks occur is not known. It is postulated that they could be due to paroxysmal neuronal discharge in partially deafferented brainstem nuclei; to irritation of tracts with transversely spreading neuronal activation; or to rapidly reversible functional interruption of tracts.

It is important to recognize these paroxysmal symptoms. They often occur early in the disease, and may obscure the diagnosis. When they do occur they are a source of considerable morbidity, and it is therefore encouraging that they appear to respond so readily to treatment with carbamazepine. □

Effect of Haloperidol and Lithium Carbonate in Huntington's Chorea

N. V. B. Manyam, MD and E. Bravo-Fernandez, MD, Wood VA Center

In an advanced case of Huntington's chorea, haloperidol therapy did result in improvement, but not sufficient to measure by functional assessment. When lithium carbonate was added in a dosage of 300 mg three times daily, maintaining a blood level around 0.6 mEq per L, the improvement was significant. Motion pictures were taken before treatment, when taking haloperidol, when taking lithium carbonate, and then when taking both of the drugs together.

In another patient with advanced Huntington's chorea with both mental change and explosive voluntary movements, who had undergone bilateral thalamotomy, haloperidol therapy alone brought significant improvement. Motion pictures were taken for comparison before and after treatment.

In the third patient, haloperidol therapy brought remarkable improvement in facial tics. Motion pictures were taken before and after treatment. □

Thoracic Epidural Lipoma Producing Spinal Cord Compression

John L. Bender, MD, John H. Van Landingham, MD, and Nicholas J. Manno, MD, Madison

Epidural lipomas producing spinal cord compression have been infrequently reported in the literature. We are presenting two previously unreported cases of such an entity. The first patient was a 50-year-old lady, who had a thoracic epidural lipoma at D6 to D8 removed in 1959, with total neurological recovery, only to have a recurrence of symptoms 12 years later. Repeated laminectomy in 1971 again revealed an epidural lipoma at the same level. Excision of the mass again caused clearing of her symptoms. The second patient was a 58-year-old white man with a 5-month course of progressive paraparesis and dysesthesia without pain, who initially refused surgery. Four months later, because of increasing disability, he submitted to surgery, and a D6-D9 epidural lipoma was excised. He subsequently recovered. □

Celontin Metabolism In Man

Stephen A. Barron, MD, and Harold E. Booker, MD, Madison

During the routine determination of anticonvulsant drug levels in the serum of patients followed in the Epilepsy Clinic, University of Wisconsin Hospitals, no methsuximide (Celontin®, Parke-Davis) could be detected by gas-liquid chromatography in any patient who had been taking that drug. Instead, a metabolite, ultimately shown to be the N-demethylated derivative, was found in high concentrations.

Ten patients were studied. The duration of methsuximide therapy ranged from one month to ten years. All patients were taking other anticonvulsant medication: nine were taking, among other drugs, either phenobarbital or drugs which underwent biotransformation into phenobarbital (primidone or mephobarbital). One patient was taking diphenylhydantoin in addition to methsuximide. The mean methsuximide level in the serum was 0 μg per ml. The mean level of the N-demethyl derivative was 33 μg per ml (range: 19-64 μg per ml).

An additional patient underwent initiation of methsuximide therapy while in the hospital in psychomotor status. He was also taking mephobarbital. Seizures stopped while the level of the N-demethyl metabolite was rising, but there was no detectable methsuximide in the serum.

Thus, evidence was presented that the N-demethyl derivative is the active form of methsuximide in man. Prior exposure to phenobarbital or to methsuximide itself facilitates the metabolic conversion. □

Figure 1—Lateral view of the left knee showing the popliteal cyst extending superiorly and the distended suprapatellar pouch.

SYNOVIAL SPOROTRICHOSIS

A Case Report and Its Management

TYRONE ARTZ, MD; JEFFREY THOMAS, MD; and ANDREW A. McBEATH, MD
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In 1898, Schenck[1] first described sporotrichosis in an iron worker who had developed the localized lymphatic type after scratching his index finger on a nail. Schenck and Smith[2] cultured the organism and placed it in the genus Sporotrichum. In 1900, Hektoen and Perkins[2] reported a second case and designated the organism Sporotrichum schenckii. Bone and joint involvement is rare, only 30 cases having been reported in the English literature.[3] The purpose of this paper is to present a case and offer suggestions for management.

Case Report

A 58-year-old white male papermill worker was first admitted to the hospital on May 22, 1967. He was an avid gardener and had been pricked frequently by thorns and twigs. He had lived in Wisconsin his entire life. His chief complaint was easy fatigability. A chronic granulocytopenia and marrow hypoplasia, etiology undetermined, was the diagnosis. Prescribed therapy was testosterone and prednisone.

He was readmitted over two years later complaining of a painless swelling of the left elbow, left wrist, left long finger, and left knee. A draining ulcer on the dorsum of the left hand followed incision of a nodule.

A physical examination showed synovitis and effusion of the left knee joint and a large popliteal cyst (Fig 1), an ulcer on the dorsum of the left hand overlying the interval between the third and fourth metacarpal shafts, and synovitis with effusion of the proximal interphalangeal joint of the long finger. A boutonniere deformity was present in this finger (Fig 2).

Roentgenographic examination of the left knee was normal except for soft tissue changes consistent with the popliteal cyst and joint effusion. There was narrow-

Figure 2—Extensor surface of the left hand showing the characteristic crater-like ulceration with circumferential induration. Several smaller ulcers can be seen over the radial aspect of the wrist. The proximal interphalangeal joint of the long finger is effused with a secondary boutonniere deformity.

From the Division of Orthopedic Surgery, University Hospitals, University of Wisconsin Medical Center, Madison, Wisconsin.
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Figure 3—Asymptomatic arthrodesed left knee.

Figure 4—Dorsum of the left hand showing complete extension of the long finger proximal interphalangeal joint after synovectomy and repair of boutonniere deformity, and complete healing of the lesions on the dorsum of the hand and wrist.

Figure 5—Palmar view of the left hand showing full flexion of the long finger proximal interphalangeal joint.

ing of the proximal interphalangeal joint space of the left long finger. Pancytopenia existed with a hematocrit of 32 vol %, hemoglobin of 10.5 gm, white blood cell count of 2,300 per cu mm and a platelet count of 9,000. Skin tests for tuberculosis, histoplasmosis, blastomycosis, and coccidioidomycosis were negative. Complement fixation titers for histoplasmosis, blastomycosis, and coccidioidomycosis were negative. The fluorescent antibody test for sporotrichosis was positive.

Initial treatment was an oral supersaturated solution of potassium iodide. Only the skin lesions improved, the synovium of the finger and knee did not respond. Amphotericin B was then added to the treatment. He received a total intravenous dosage of 1.0 gm of amphotericin B over a five week period. Intra-articular amphotericin B was also administered twice a week into both joints and the popliteal cyst. One mg of amphotericin B in 1.0 ml of saline was injected into the proximal interphalangeal joint and 25 mg in 10 ml of saline into the knee joint and popliteal cyst.

The patient was readmitted three months later because there had been only slight decrease in the synovial reaction in the proximal interphalangeal joint and popliteal cyst. Two days later the popliteal cyst of the left knee was excised. A synovectomy of the proximal interphalangeal joint and repair of the extensor mechanism was performed. After surgery the proximal interphalangeal joint was immobilized in a safety pin splint for three weeks. Cultures of the fluid from the popliteal cyst grew out Sporotrichum schenckii.

After another four months, he was readmitted to the Orthopedic Service having developed increased effusion of the left knee joint and recurrent swelling of the posterior distal left thigh. Examination revealed a large cystic lesion extending from the left popliteal region to the mid-posterior thigh. There was a moderate effusion with synovial thickening of the knee joint. A left anterior knee synovectomy was performed. The synovium was markedly thickened with many associated large, pale, yellow rice bodies. Multiple areas of frayed articular cartilage were noted. The operative incision healed primarily. Two days prior to synovectomy the patient had been started on amphotericin B which was continued after surgery to reach a total dosage of 1.0 gm. The drug was administered intravenously at the rate of 20 to 60 mg every other day during a six-week period. Fluid cultured from the left knee at the time of synovectomy grew out Sporotrichum schenckii. At the time of discharge the Hematology Staff recommended continuation of testosterone and prednisone for treatment of his marrow hypoplasia.

In July 1970, the patient returned to the hospital three days after developing fever, chills, and knee drainage. Examination revealed a pale, cachectic man with a temperature of 40.5 C (105 F). Two sinus tracts draining purulent material existed over the anterior aspect of the left knee. The knee was swollen, hot, and erythematous. The patient required six units of whole blood to control an upper gastrointestinal hemorrhage which developed soon after admission. Cultures of the left knee drainage grew out Staphylococcus aureus coagulase positive, pseudomonas organisms and Sporotrichum schenckii. Blood cultures also grew out Staphylococcus aureus. The patient was initially started on large doses of intravenous methicillin and amphotericin B (110 mg of amphotericin B were given over a five-day course). After six days, the patient's systemic symptoms had improved sufficiently to allow debridement and installation of irrigation tubes through which a solution of methicillin and gentamicin was passed. Postoperatively the intravenous methicillin and amphotericin B (325 mg given in 17 days) were continued. Systemic symptoms markedly improved but he continued to have a purulent drainage from the left knee. Two months after this admission a successful left Charnley knee arthrodesis was performed, although an amputation had been considered.

When last seen in March 1972, the patient's left knee was solidly arthrodesed (Fig 3). The left hand had remained asymptomatic with a full range of motion of the proximal interphalangeal joint of the long finger (Figs 4 and 5). No evidence of infection was seen at any site.

Discussion

Sporotrichosis has worldwide distribution. In the United States, it is most prevalent in the Midwest.[4] Man usually contracts sporotrichosis through a wound which has come in contact with an infected plant or plant matter. Thus, it most frequently occurs in farmers, gardners, florists, and fruit pickers.[4]

Sporotrichosis has been divided into three subtypes: localized lymphatic, gummatous disseminated, and extracutaneous or systemic.[5] Bone and joint involvement has been reported to occur in 10% of systemic cases.[6] The knee is the most common joint involved (43% of 30 cases[3]) and the tibia the most common bone involved (29% of 30 cases[3]).

This fungus is very difficult to identify in a biopsy specimen. The most reliable method of identification is by culturing a biopsy specimen on Sabouraud's glucose agar.[4]

The diagnosis of sporotrichosis must be considered in any patient who has multiple cutaneous nodules which develop central ulceration and surrounding infiltration. These lesions will usually present on the upper extremity,[4,7] located along lymphatic channels but without the usual inflammatory signs of bacterial infection.

The differential diagnoses include syphilis, tuberculosis, pyogenic infection, tularemia, nodular leprosy, blastomycosis, actinomycosis, coccidioidomycosis, histoplasmosis, squamous cell carcinoma, and cutaneous granulomata caused by drugs.[4,5,7]

Previous writers[4,6,7,8] have stated that lowered resistance is likely to be present in individuals who develop sporotrichosis, as did our patient. He had chronic granulocytopenia with marrow hypoplasia and had been receiving systemic steroid since May of 1967. This has been discussed by Manhart, et al,[9] who presented this case in part and discussed its medical aspects.

A supersaturated solution of potassium iodide given orally is the treatment of choice for the cutaneous lesions, which will clear within four to eight weeks.[4,7] Iodides have not been effective in treatment of the systemic disease. The drug of choice for systemic sporotrichosis is intravenous amphotericin B, although griseofulvin, stilbamidine, and 20 hydroxystilbamidine have shown some good results.[7,10,11] Intra-articular amphotericin B was tried because of its reported success in the treatment of coccidioidomycosis[12] but was unsuccessful in our patient with sporotrichosis. Until better chemotherapy is found, our suggestion is to operate on synovial sporotrichosis as soon as possible. The diseased synovium is invasive and does not respond predictably to drug therapy. Thus, delay in synovectomy will result in greater joint destruction requiring an eventual arthrodesis or amputation for control of the disease. The prognosis for treatment of the systemic disease should always be guarded.

Summary

A patient is presented with systemic sporotrichosis who had pre-existing granulocytopenia, marrow hypoplasia, and was receiving systemic steroids. Initial treatment with oral supersaturated solution of potassium iodide healed only the cutaneous lesions. Intravenous and intra-articular amphotericin B was added to the treatment program with minimal response from the synovial tissue. Only synovectomy of the long finger proximal interphalangeal joint was successful. Later synovectomy of the knee was unsuccessful.

Our recommendations for treatment of systemic sporotrichosis with synovial involvement consists of:

(1) Initial administration of intravenous amphotericin B.

(2) Synovectomy and debridement as soon as possible to prevent destruction necessitating arthrodesis or amputation.

(3) Continued close observation.

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Cross-Sensitivity and Aminoglycoside Antibiotics

WILLIAM F SCHORR, MD et al, Marshfield, Wis: *Arch Dermatol* 107:533–539 (Apr) 1973

In 20 neomycin-allergic patients as well as 50 normal control volunteers, 48-hour patch tests were applied in varying dilutions to neomycin, gentamicin, and a new aminoglycoside antibiotic, butirosin sulfate (ambutyrosin; Cl-642). Also, intradermal tests to all antibiotics were performed on all patients as well as control volunteers. From this study the authors conclude the following: (1) False–positive patch tests or intradermal responses did not occur in 50 control volunteers to any of the antibiotics in any of the concentrations used. (2) In the 20 neomycin-allergic patients cross-sensitization exists with gentamicin (55%) and butirosin (90%). (3) Butirosin should not be used to treat neomycin-allergic patients when it becomes commercially available. □

Psychiatry in the Milwaukee Area: A Survey

DONALD J. CAREK, MD, Milwaukee, Wisconsin

A questionnaire survey of the 122 psychiatrists in the Milwaukee Metropolitan area was conducted in October 1972. The primary aim of this survey was to estimate the relative saturation of psychiatrists in private practice in this area. The second aim of the survey was to learn something about these psychiatrists and their practices. The following conclusions are drawn from the 72 completed questionnaires.

1. There is not a gross deficiency of psychiatrists in the Milwaukee Metropolitan area.
2. A profile of the average Milwaukee area psychiatrist emerged along these lines.

- He is primarily an outpatient psychiatrist.
- His patients are primarily adults. He is likely to see some adolescents, but unless a child psychiatrist he does not see children.
- He provides some direct care to patients through part-time employment in a clinic or in a hospital.
- He does some consultation work, most often in a hospital.
- His major sources of referrals are non-psychiatric physicians, other patients, and other psychiatrists.
- He appears to be as busy as he wants to be.
- For treatment, he relies on eclectic psychodynamic psychotherapy, primarily in a dyadic relationship, on a once-a-week basis, and occasionally twice a week. He uses medication moderately in his care of patients. If he elects to see patients in a group, he is most likely to engage in conjoint or family therapy.
- He is at least board eligible and likely to be board certified. If eligible, he is planning to take board examinations.
- He has a faculty appointment with the Medical College of Wisconsin.
- He sees psychiatry as founded in Medicine and he cherishes his identity as a physician.
- His patients are inclined to present with adaptational problems which he sees to be manifestations of neurotic and personality disorders.

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Management of Tetanus

DONN D'ALESSIO, MD
MARVIN BIRNBAUM, MD
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In the past two decades 31 patients with tetanus have been treated at the University of Wisconsin Hospitals with an overall case-fatality ratio of 28 percent. Sixteen of these patients were over 50 years of age and 37 percent of this group died as a result of their disease. There has been no downward trend in admissions over this 20-year period as five tetanus patients were treated during 1971 and 1972. Since the disease is confined almost solely to unimmunized persons, this may reflect a large number of unimmunized adults in Wisconsin.

Nationally in contrast, reported cases of tetanus have fallen from about 500 per year in 1950 to 116 in 1971. A recent review of the national situation[1] reveals that the case-fatality ratio has remained distressingly high (61%) and has changed little in the past two decades. In over 90 percent of cases, the predisposing wound was obvious at the onset of tetanus. This was true in both the national series and in the patients seen at University Hospitals. More than 50 percent of cases occur in persons over 50 years of age. The continued occurrence of this disease in unimmunized persons is unfortunate since tetanus toxoid is one of the most effective immunizations in current use with evidence that children given an initial course of four injections are protected for more than 12 years.[2]

The situation facing the medical profession then is that tetanus occurs rarely but is quite lethal. Treatment is not specific, highly complex, prolonged, and expensive. In few other afflictions, however, does the outcome rest so directly on the skill and devotion of those caring for the patient. For these reasons, we feel it worthwhile to review the management of this disease.

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Diagnosis

In tetanus, the diagnosis is solely a clinical one. There is no generally available method to detect the toxin in the blood and even in the best of circumstances, the causal organism, *Clostridium tetani,* is isolated from the wound in less than 30 percent of cases. Trismus and dysphagia are usually presenting complaints; accompanied with muscle rigidity, spasms, and convulsions, the diagnosis is not difficult. But the spectrum of the disease is wide and in mild cases or early in the disease diagnosis may be difficult. Most cases occur within 14 days of the precipitating injury; and generally the shorter the incubation period (7 days or less), the greater the severity of the disease and the higher the mortality rate.

Management

There is no specific therapy for tetanus and the physician is faced with supporting the vital functions of the patient while the disease runs its course. There are a number of questions concerning optimal management which remain unresolved and the following presentation represents a consensus of current therapy.

Wound Care, Antibiotics, and Antiserum

Generally it is accepted that toxin is irreversibly bound to neural tissue and is removed only by metabolism of the toxin complex. Therefore, wound care and the administration of antibiotics and antiserum are directed toward halting further production of the toxin and neutralizing whatever free toxin exists in the blood and other body fluids. If the patient presents with no obvious wound, a vigorous search should be undertaken. Usually the offending wound is obvious and there is no question that drainage and surgical debridement with removal of all devitalized tissue is essential. Often the wound is infected with a variety of organisms.

If the place for surgical debridement is unquestioned, the efficacy of antibiotics and serotherapy is less well established. This is especially so because no single center accumulates sufficient cases to study in a controlled prospective fashion. In 1965, the Center for Disease Control (CDC) established a

national tetanus surveillance system. In 1969, the analysis of antibiotic and serologic therapy for patients studied in 1965 and 1966 was published.[3]

The case-fatality ratio in those receiving penicillin G either alone or with another antibiotic was 66 percent compared to 69 percent in those not treated with antibiotics. It has not been shown then that antibiotics beneficially affect the outcome of tetanus. This is not surprising since proper wound care should have the identical effect in eliminating the source of infection and toxin production. Nevertheless, penicillin G is commonly administered.

The findings with serotherapy are more variable and difficult to interpret. The CDC study showed a significant reduction in case-fatality ratio in those patients who were given 50,000 units or more of heterologous tetanus antitoxin (TAT), (57 percent compared to 81 percent in the untreated group). In recent years, human tetanus immune globulin (TIG) has become available and has largely replaced antiserum of animal origin because it results in fewer allergic reactions and a longer antibody half-life. In the CDC analysis of the 1965-1966 experience, no benefit in case-fatality ratio was seen in those receiving TIG. However, more recent data demonstrate that TIG in a dosage of 3,000 to 5,000 units reduces mortality compared to an untreated group.[4]

Life Support

As mentioned, the clinical spectrum in this disease is very broad and the milder cases may need nothing more than close observation until it is clear that there will be no progression. In the severe form of the disease, however, the most serious clinical problem is the tetanic contraction of skeletal muscle groups. Such contractions are extremely painful and interfere with deglutition and ventilation. The patient frequently aspirates his own secretions and as the severity of the disease progresses, ventilatory failure ensues. Therapy, therefore, is directed at prevention and relief of these tetanic paroxysms.

Tetanic contractions are often provoked by loud noises, flashes of bright light, and sudden jostling of the patient. Hence, an essential part of the treatment plan is management of the patient in a quiet, semidarkened environment by a staff who is understanding and gentle.

Generally the most appropriate therapy of the tetanic spasms is blockade of neuromuscular transmission with curare. Paralysis with tubocurarine is achieved with an initial intravenous dose of 0.3 to 0.6 mg/kg. Paralysis is then maintained by 0.1 to 0.2 mg/kg/hr intravenously.

Neuromuscular blockade carries two serious problems. First, since the muscles of respiration are paralyzed, the patient requires long-term ventilatory support. Until the past year, the necessary airway was provided by a tracheostomy and cuffed tracheostomy tube. Recent technological advances now offer a new option. Silicone clad endotracheal tubes with low pressure cuffs placed through the nose have been used to support paralyzed patients successfully for 7 to 8 weeks. This alternative eliminates the need for tracheostomy. The incidence and severity of complications from prolonged intubation are no greater than from tracheostomy. If a tracheostomy is done, a similar silicone clad tube with a low pressure cuff should be used rather than the conventional metal tube with a latex rubber balloon.

Tracheobronchial toilet for secretions and hence prevention of atelectasis and infection must be performed with sterile technique. Deep suctioning must be done with care and preferably associated with artificial coughing maneuvers using an anesthesia bag. Suctioning time should be minimized, and the character of the secretions obtained should be recorded. Collection of these secretions for gram-stain and bacterial cultures should be done several times each week. Appropriate antibiotic therapy should be given for bacterial growths which are associated with large numbers of pus cells and/or pulmonary infiltrates. Antibiotic therapy is not appropriate for organisms which grow on culture but are not associated with pus or pneumonitis.

Ventilatory support may be provided in several ways: iron-lung; chest cuirass; rocking bed; volume or pressure cycled ventilator. As noted above, it is essential to keep extrinsic stimulation of the patient minimized, and hence external ventilatory support with the iron-lung or chest cuirass is not ideal. Best support is provided by a volume-cycled ventilator. The tidal volume and frequency should be adjusted using arterial blood gas measurements as an indicator, since the metabolic activity of these patients varies substantially during the course of the disease. Once spasms are controlled, intensive chest physical therapy and passive range of motion to prevent contractures should be initiated.

The second major problem resulting from neuromuscular blockade is the intense anxiety that total paralysis and inability to communicate produce. It is important to always bear in mind that although the patient lies unmoving in bed and is unable to communicate, he is alert and generally is aware of his environment. He hears all that is said at the bedside, and all assaults with needles, suction catheters, movements of body parts, and the like should be thoroughly explained. Careful attention to

this part of the care plan helps to allay a substantial part of the anxiety.

Anxiety is managed further through the use of sedation or tranquilization. In Britain, paraldehyde is preferred but in the United States, diazepam (Valium) has become the most commonly used drug. Frequently doses of 5 mg/hr of diazepam have been required. However, this drug should be used with caution as its action can be cumulative and the effects of frequent, repetitive doses can be quite prolonged, a situation which has occurred in several of our patients. Since normal methods of dose titration are not possible in these paralyzed patients, blood levels of these agents are useful in dose adjustment (0.5 to 1.5 μg%).

In addition to a need to meet nutritional requirements from 4 to 8 weeks, the risk of gastrointestinal hemorrhage is quite high. These problems can be met best by feeding through a nasogastric tube at 3 to 4 hour intervals. Excellent commercially available, high caloric, high protein preparations (High Nitrogen Vivenex and Meritene) have proved quite useful in optimizing nutritional status and minimizing the incidence of gastrointestinal bleeding. With this approach, 2000 to 3000 calories per day can be provided and a severe catabolic state avoided.

Many patients afflicted with clinical tetanus manifest spontaneous oscillations in sympathetic activity, particularly within the first week of the disease.[5] Ventricular dysrhythmias are not an uncommon cause of death during this period, and all patients should be continuously monitored for these dysrhythmias throughout the clinical course. In addition severe peripheral vasoconstriction producing a 'shock-like' picture is encountered in approximately 25 percent. Hence, fluid balance must be carefully controlled and observation for the subtle onset of lactic acidosis secondary to tissue hypoperfusion is essential.

Skin care must be optimal to avoid prolongation of hospitalization and delay in initiation of rehabilitation. As the disease begins to wane, supportive measures are gradually withdrawn. Neuromuscular blockade is maintained at the lowest level which prevents tetanic contractions; and when the patient can resume adequate ventilation, the anti-anxiety drugs are stopped. It must be recalled that clinical tetanus does *not* immunize the patient; and before leaving the hospital, a full program of immunization must be initiated. In adults, this consists of 3 doses of alum precipitated toxoid, the first two 4 to 6 weeks apart and the third 6 to 12 months later.

A substantial physical rehabilitation program starting gradually and progressing slowly is important to the patient. This usually requires 10 to 30 days following the withdrawal of all forms of support.

The successful management of this disease is a trial to both the patient and those caring for him. The efforts required are entirely warranted, however, because those who survive usually return fully to their previous state of health.

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Glucose, Insulin, and Free Fatty Acids in Uremia

DONALD A ROTH, MD, PhD; ROBERT C MEADE, MD, MS; and JOSEPH J BARBORIAK, PhD, Wood VA Hosp and Medical College of Wisconsin, Milwaukee, Wis: *Diabetes* 22:111–114 (Feb) 1973

Glucose intolerance in uremia is well known. The mechanism of this abnormality remains obscure. Insulin insensitivity related to growth hormone, acidosis, potassium depletion, and nitrogenous toxins have been suggested as possible contributing factors. We have again confirmed glucose intolerance in 11 uremic patients during standard 3-hour glucose tolerance testing. Plasma free fatty acids are markedly depressed when glucose and insulin are elevated. The depression of FFA is greater in uremic patients than in normal subjects when very small amounts of insulin are infused over a period of 30 minutes. This additional sensitivity to insulin may be a significant metabolic abnormality in uremia. Under conditions of prolonged hyperglycemia and hyperinsulinemia during peritoneal dialysis the plasma FFA concentration of uremic patients remains very low. The role of depressed FFA as a factor in uremic neuropathy is speculative at this time. □

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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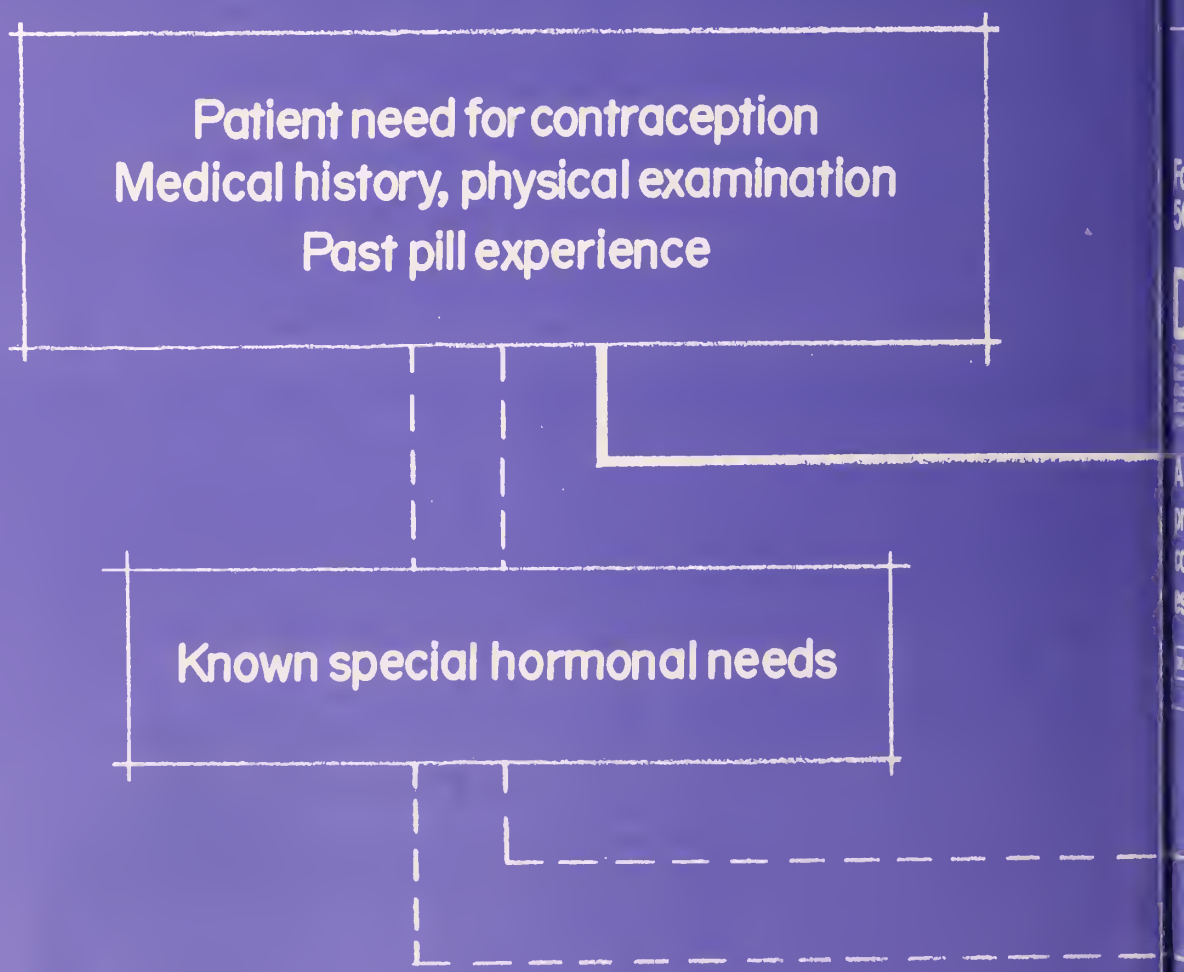

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 10 OCTOBER 1973

FROM THE PRESIDENT

With One Clear Voice

THE PAST DECADE HAS WITNESSED some of the most significant changes in the history of American medicine. What was once considered private enterprise has been transformed into a vast public-private endeavor. Witness the changes since the advent of Medicare. The list of legislative proposals, both federal and state, is long and has far-reaching effects on all of our lives and practices. The most recent federal bill relates to PSRO (Professional Standards Review Organization). On the state level, legislative policy programs exemplified by AB 489 have been proposed.

It has been stated that medicine is being slowly politicized and federalized. Pressures come from politicians, press, and members of our own rank. The word 'crisis' is continually used with little justification. Frustrated and bewildered, physicians forsee more "take over" by government and a gradual erosion of their rights and decision-making. Increasingly the word 'union' surfaces. Those who foster this idea would speak with a big stick and apply pressure in the form of strikes to gain their ends and apply resistance to federal and state government intrusions. These same individuals claim the existing medical structures are not defending their best interests and there is need for change in organizational makeup.

Resolution of our problems and resulting utopia will not be found by endorsing either federalism or unionism. Our strength will continue to be in our dedication to hard work and excellence in our standards of care and our support of one unified voice through organized medicine. Divisionism is an invitation to government. We should continue to carry the ball. More and more politicians seek our advice and look to us for the solution of the problem, and less and less we are viewed as part of the problem. This is the time of opportunity and the time of challenge. Your effect will be felt and your voice will be heard through your organization and its leaders. We must speak—"with one clear voice."

G. J. Derus M.D

SCULPTURE DEDICATION IN PROGRESS AT PRAIRIE DU CHIEN

DR. WILLIAM S. MIDDLETON

DR. WALTER ZEIT

CESF

Medical Art and Memories

Tales from early in the century of double dealing undertakers and intellectual hostages from Wisconsin were told September 8 at the dedication of a modern metal sculpture in Prairie du Chien.

The sculpture, honoring Wisconsin medicine of the past, present and future, was recently completed at the Museum of Medical Progress. About 100 people from around the state were at Prairie du Chien for the dedication luncheon and program. The museum is owned and operated by the State Medical Society's Charitable, Educational and Scientific Foundation.

Walter Zeit, PhD, professor of anatomy emeritus at the Medical College of Wisconsin, Milwaukee, regaled luncheon guests with his tales of the early days of medical education in Wisconsin.

One highlight was the story of an undertaker who was collecting twice for his work with deceased indigents. The county paid him to bury the indigents in a potter's field. Instead, he buried empty boxes and collected another fee from the Wisconsin College of Physicians and Surgeons in return for bodies for anatomy dissection cadavers. Eventually, Dr. Zeit said, the story hit the newspapers and became a full blown scandal.

At the dedication ceremony William S. Middleton, MD, dean emeritus and professor of medicine at the University of Wisconsin Medical School, talked about the development of the state's medical education. He called such great Wisconsin physicians as Dr. Nicholas Senn, John B. Murphy, and Frank Billings "intellectual hostages from Wisconsin" in the days before 1907 when the University of Wisconsin began teaching medical students. These Wisconsin men had to seek their training in Chicago in those days.

Hostesses for the program were members of the Aesculapian Society, physicians' spouses who promote the Museum. □

MEDICAL GREEN SHEET is published monthly as a special feature in the Wisconsin Medical Journal, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

CMCP

Reappointed/Reelected

E. M. Dessloch, MD, Prairie du Chien, has been reappointed chairman of the Commission on Medical Care Plans (CMCP) by the State Medical Society's Council.

At its last meeting, September 29, the CMCP reelected the following officers: MDs Robert Krohn, Black River Falls, vice-chairman; John T. Sprague, Madison, WPS treasurer; Max M. Smith, Madison, assistant treasurer; David N. Goldstein, Kenosha, delegate to the National Association of Blue Shield Plans (NABSP); and W. T. Casper, Milwaukee, alternate NABSP delegate.

The following were reappointed to CMCP for three-year terms: MDs Paul B. Mason, Sheboygan; E. J. Nordby, Madison; D. J. Ottensmeyer, Marshfield; A. H. Stahmer, Wausau; and Messers. Dayton F. Pauls, Sheboygan, and David L. Vogel, Madison. □

Communicating Across the Gap

"Broaden this convention to individual schools if possible!! The speakers were frank and eloquent and the group discussions solidified in my mind the ideas presented."
—Eau Claire teenager

"I regard this teen-adult experience as being so valuable that I dare to hope it can be repeated annually."
—Madison adult

These comments indicated the general enthusiasm by high school teenagers, their teachers and parents, and others who attended the 11th annual Wisconsin Work Week of Health Oct. 2-4 in Madison.

The State Medical Society's headquarters was filled to capacity and extra space was rented across the street at the local VFW Hall to accommodate some 500 people each day.

Through the three days of articulate speakers coupled with discussion groups, the kids and the adults were able to learn and talk about teenage problems.

As the result of extensive mailings to schools and social service workers and the work of the Woman's Auxiliary to the State Medical Society, attendees were present from across the state. Many schools sent bus loads.

The topics were not new ones, but rather those perennial problems of adolescence that boil down to growing up and learning to cope with the adult world. Keynote speaker Seymour Halleck, MD, sketched part of modern teens' problems in these terms: "Adolescents today, growing up in the post-sexual revolution era, have less severe neurotic conflicts about sex than did their elders . . . On the other hand increased sexual freedom carries its burdens . . . At the moment sexual behavior among youth is too often reminiscent of an ethical jungle."

Throughout the week, the speakers talked about teenagers and sexuality, drugs, values, and parents. In a variety of ways, they challenged the students to think about such questions as:

AM I NORMAL?

Judy Jones of Planned Parenthood, Milwaukee, said the answer to this question is an individual one. She suggested that everyone must decide whether "what has been decided as normal in our society is really where you are or what you want to be or where you want to go." When asked for her opinion on whether premarital sex is all right, she said: "If you have to ask, you're not ready."

WHAT CAN WE DO INSTEAD (OF DRUGS)?

V. Alton Dohner, MS, MD, of the U. S. Public Health Service in Arizona, said people can be turned on without drugs. He very rapidly covered some "societal alternatives": alternative life styles, alternative communities, alternative schooling. He also covered a number of alternatives for individuals: meaningful work, relaxation, personal awareness, psychological awareness, development of self reliance, intellectual thrill of learning, religion, responsible sexual expression, political and social involvement, individual mind trips.

He led the audience on a mind trip to a cave overlooking a mountain lake: "If you listen hard enough, you'll hear the wind in the trees, you may even hear a few birds, and you can smell the pines." . . . Those kinds of trips are as endless as your imagination.

WHY NOT?

James Merrill, executive director of Lutheran Social Services of North Dakota, said kids today are brave enough to ask "why not have sex before marriage" unlike their parents, who were afraid to ask. He outlined some of the reasons used in nursing manuals of years ago to deal with this question. However, he said, the most important message of all to get across from parent to child is, "I care about what happens to you. I love you."

WORK WEEK TAPES

WHA Radio taped all of the speakers at the Wisconsin Work Week of Health. These will be aired on the state educational network. Sets of tapes also are being sent to radio stations around the state for their use.

Cassette tapes are available for high schools, civic clubs, county medical societies and their auxiliaries, and others for teaching purposes.

Contact the State Medical Society's Public Information Department, Box 1109, Madison, Wis. 53701, or telephone (608) 257-6781.

PANELIST-PARENT LENORE ROWE: SPEAKER CATHARINE V. RICHARDS, PhD: AND PANELIST-PARENT ROBERT BRIGHT

MODERATOR STANLEY GRAVEN, MD; SPEAKER JAMES CROW, MD; WOMAN'S AUXILIARY DIRECTOR AND GREETER-DISCUSSANT MRS. JONATHAN WILLIAMS: AND SPEAKER RICHARD ANDERSON, MD

Campers, Too, at Work Week

During the three-day Work Week program, the State Medical Society's parking lot became the campground for five young ladies and their chaperon from Sheboygan. Coming to Madison in a mobile unit, the gals spent their outing learning, having fun, but also doing some chores. They came prepared, too. The first day was "dress up" day, the second "high-waisted pants" day, and the third was "grub" day when this picture was taken. They are Karen Kruger, Lori Hanke, Debbie Marchiando, Lori Meyer, and Julie Hed. Mrs. Gordon Froehlich, aunt of Julie, is in the upper center. Summing up their stay, the girls said, "It was all worth it, and we would have come just to hear Mr. (James) Merrill; he was terrific!" But they had to miss the final speaker, Wayne Allan, who also captured the teenagers' fancy and spent some time signing autographs.

WHY DO WE DO WHAT WE DO?

Jerome Witherill, an instructor of safety education at the University of Wisconsin, Whitewater, said many people ignore health information, such as that which tells them to wear their seat belts or to not use drugs. He said one important ingredient needed to get people to do the right thing is the love concept: everyone needs to love himself so that when he does things he is doing them both for himself and for others.

He named one "disease" that can get in the way of this: skin hunger. He said anyone can catch it, but prevention is easy—just four hugs a day.

WHERE CAN TEENAGERS GO FOR HELP?

John Stephenson, MD, director of the new Teen-Age Clinic at University Hospitals, Madison, outlined the need to look at the total person before determining whether they need to see a family physician, a psychiatrist, a social worker, or some other type of person.

Dr. Stephenson, a pediatrician, says he doesn't just look at the adolescent's acne or listen to his heart. "I stick a stethoscope in my pocket and this sells me as a doctor. Then I can deal with these other problems," he said.

HOW CAN ADULTS HELP TEENAGERS?

Robert Kaplan, PhD, chairman and professor of health education at Ohio State University, said the schools will provide what the parents demand. While we cannot ignore the cognitive aspects of education, he said, in the field of health education in particular, facts are not enough.

For example, despite the surfeit of information on the hazards of smoking, people still smoke. However, he said, it is difficult to do more than just give facts—a problem health educators are working on.

One health education program he mentioned as doing more than just giving facts is the "Inside/Out" series of TV programs geared for elementary school children and now being shown on educational television in Wisconsin.

WHAT'S THE TEENAGER'S RESPONSIBILITY AS A FUTURE PARENT?

James Crow, MD, a University of Wisconsin genetics professor, said in his opinion "the right to reproduce is not a basic human right. No person has the right to knowingly produce an abnormal child." He said "if an individual has a high risk for having an abnormal child, he should do something about it."

HOW CAN ADOLESCENCE BE A WORTHWHILE EXPERIENCE?

Richard Anderson, MD, an adolescent psychiatrist at the University of Wisconsin, said the important people in a teenager's life—parents, teachers—need to help the teenager through the period of adolescence: "a scary experience."

The adolescent often fights against his parents to learn how far he can go and how to handle such conflicts with others, Dr. Anderson said. If the parent can't handle these situations, the adolescent may regress to gangs of friends and never learn to relate to another individual on a one-to-one basis.

WHAT ARE PARENTS RIGHTS AND TEENAGERS RIGHTS?

The last two speakers expressed two different viewpoints. Catherine Richards, PhD, chief of U.S. Youth Services, Washington, D.C., said being respected and treated as a person is something everyone—even a parent—deserves. Wayne Allan, PhD, of Effectiveness Training Associates, Denver, Colo., indicated he thought every parent needed to do some work to earn the respect of his children.

Dr. Richards' remarks were part of a panel on the subject "Parents are People." Two Madison parents, Robert Bright and Mrs. Lenore Rowe, told about the demands being parents made on their lives.

Dr. Allan outlined how using the system of Parent Effectiveness Training can help parents resolve conflicts with their youngsters. He called it a "no lose" approach. □

DR. LOUIS CHOSY

EDITORIAL BOARD

New Member for Journal

The Editorial Board of the *Wisconsin Medical Journal* has been enlarged and restructured at the request of the State Medical Society's Council.

It now is composed of seven members, including one new member. The Medical Editor, who heretofore had been chairman of the Board but not a member, is now a member and remains its chairman.

The new member is Louis W. Chosy, MD, an associate clinical professor of medicine at the University of Wisconsin-Madison Medical Center. As a specialist in internal medicine, his particular field of interest is pulmonary disease.

A native of Columbus, Ohio, Dr. Chosy received his undergraduate and medical education at Ohio State University, graduating in 1959. An internship and residency were served at the University Hospitals in Madison. He was granted a Wisconsin license in 1961.

From 1959-1966, Dr. Chosy served with the U.S. Army National Guard in Wisconsin.

Joining the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association in 1967, Dr. Chosy has been active in organized medicine.

In 1969 Dr. Chosy was appointed to the State Society's Commission on Health and Natural Resources. He was reappointed in 1972 with his term expiring in 1975.

In October 1972 the Society's Council authorized the addition of a sixth member to the Editorial Board and at the same time made the Medical Editor a member of the Board with continuation as chairman.

The Bylaws were revised to allow the Editorial Board broader responsibilities. Where they previously had required that the Commission on Scientific Medicine be in charge of the scientific affairs of the *Journal*, with important questions of editorial policy being submitted to the Council, the Bylaws now state that the Editorial Board is in charge of the *Journal* affairs, but subject to policy direction of the Council.

Other members of the Editorial Board are: MDs Victor S. Falk, Edgerton, medical editor and chairman; Garrett A. Cooper, Madison; Melvin F. Huth, Baraboo; Leslie G. Kindschi, Monroe; Merlyn C. F. Lindert and David W. Ovitt, Milwaukee. □

Choosing the Top Society Officers

Who chooses the State Medical Society's candidates for top office?

Until now, the process has been done during the Annual Meeting by the Committee on Nominations.

In an effort to involve more Society members in the process, the procedure for nominations was changed by the House of Delegates at the last Annual Meeting.

At 10 a.m. Saturday, November 3, for the first time the Committee on Nominations will convene in advance of the Annual Meeting to hear suggestions for next year's officers. The meeting, at the State Medical Society's headquarters in Madison, coincides with the fall meeting of the Council.

Every member of the State Medical Society is invited to come and express his views, make suggestions in advance to his councilor district representative on the committee or address a letter to the committee at State Medical Society headquarters.

This year nominations are in order for the following offices:

President-elect (now J. E. Dettman, MD, Green Bay)

Vice-speaker (now Patricia Stuff, MD, Bonduel)

AMA delegates for seats now held by: J. M. Bell, MD, Marinette; G. E. Collentine, Jr., MD, Milwaukee; and C. J. Picard, MD, Superior.

AMA alternate delegates for seats now held by: E. M. Dessloch, MD, Prairie du Chien; D. J. Carlson, MD, Milwaukee; and H. J. Kief, MD, Fond du Lac.

The candidates chosen at this meeting will be publicized in the February issue of the *Wisconsin Medical Journal*. Additional nominations can then be made at the March 26 meeting of the House of Delegates, in Milwaukee, before the delegates vote on the new officers.

Members of the Committee on Nominations were elected at the last session of the House of Delegates in March during the Society's 1973 Annual Meeting in Milwaukee. There is one representative from each of the 13 Councilor districts of the State Medical Society and one representative of all of the Society's scientific sections.

They are Doctors: (Councilor District appears in parentheses)

John D. Riesch, Menomonee Falls (1st)

Raymond G. Welsch, Kenosha (2nd)

James N. Moore, Madison (3rd)

James J. Tydrich, Richland Center (4th)

Robert M. Senty, Sheboygan (5th)

James G. Bergwall, Hortonville (6th)

James T. Murphy, La Crosse (7th)

Kenneth L. Strebe, Oconto Falls (8th)

John B. Wyman, Marshfield (9th)

L. O. Simenstad, Osceola (10th)

Charles J. Picard, Superior (11th)

Chesley P. Erwin, Milwaukee (12th)

Theodore C. Fox, Antigo (13th)

Joel E. Taxman, Milwaukee (Scientific Sections) □

UW-MADISON

New Dean

The University of Wisconsin-Madison Medical School has a new dean. He is Lawrence G. Crowley, MD, an associate dean and acting chairman of surgery at the Stanford University School of Medicine. Doctor Crowley also became professor of surgery October 1.

Announcement of the appointment was made September 7 at the University of Wisconsin System Board of Regents who had previously authorized the position.

Two other major Center for Health Sciences administrative appointments were made at the same time. Acting dean, Henry C. Pitot, MD, whom Dr. Crowley replaces, was named director of the McArdle Laboratory for Cancer Research.

Named associate vice chancellor for health sciences was William G. Davis, Washington, D.C.

A physician with wide experience in clinical practice, education, and research, Dr. Crowley, 54, received his medical degree from Yale University School of Medicine in 1944.

DR. LAWRENCE CROWLEY

Dr. Crowley has been in practice with the Southern California Permanente Group, was in the private practice of surgery, has worked with the Veterans Administration system as well as having taught and done research at Yale, Southern California, and Stanford.

"Dr. Crowley is eminently qualified for the deanship at Wisconsin and will assist us greatly in the development of our Center," according to Vice Chancellor for Health Sciences Robert E. Cooke, MD.

Dr. Pitot, a UW faculty member since 1960, was chairman of pathology before being named acting dean of the medical school in October 1971.

"Dr. Pitot provided the medical school with excellent leadership during a very critical period of its history and greatly aided in developing the groundwork for our Center for Health Sciences," according to Dr. Cooke. "The Center and the medical school will always be grateful for his efforts.

William Davis, a naval commander and former assistant comptroller for budgeting and financial management of the Navy's bureau of medicine and surgery, will serve as executive assistant to Vice Chancellor Cooke. □

SMS Committees *in action*

Committee Appointment. David Foley, MD, Chairman of the Division on Maternal and Child Welfare, at the Division meeting August 10 appointed Gertrude Howe, MD to serve as a consultant to the Inter-Divisional Committee on Foster Care of the Department of Health and Social Services.

Health Occupations Brochure. Commission on Health Information, August 30, agreed that the State Medical Society should produce a brochure designed to educate the public on how the various medical specialties and paramedical groups fit into the health-care picture. One aim of the brochure is to clarify the difference between sound alike terms such as ophthalmologist, optometrist, and optician and podiatrist and pediatrician. Commission members will review the information before publication.

Conference on Physicians and Schools. Division on School Health, September 6, agreed that the Conference on Physicians and Schools which it is planning to sponsor for the state of Wisconsin should focus on what physicians can do to assist schools. The Division recommended that the program include school administrators and board members and emphasize the need for improved physical education programs. It was agreed that the program should be done in cooperation with the Wisconsin Interscholastic Athletic Association.

Residency Programs. Commission on Hospital Relations and Medical Education, September 20, endorsed a recommendation by representatives of the University of Wisconsin Medical School and the Medical College of Wisconsin that the residency programs of Milwaukee be made attractive to graduates of the University of Wisconsin Medical School and in like fashion those existing in Madison be made attractive to graduates of the Medical College of Wisconsin. □

BLOOD PRESSURE

Fair Test

One attraction at this year's Wisconsin State Fair, August 10 to 19, was a free blood pressure screening sponsored by Northwestern Mutual Life Insurance Company.

A total of 7,449 people took advantage of the test and more had to be turned away. Each person got a form giving his blood pressure reading and this message: "The World Health Organization defines casual blood pressure readings of 160/95 or above as hypertensive. Although your reading was taken under unusual conditions, it is wise to test blood pressure regularly and to seek medical advice when readings are abnormal."

For their own records, however, the company kept count of the number of readings above 140/90. By this gauge, 35% of those tested had high blood pressure. This included 44% of the 3,294 men tested and 28% of the 4,155 women.

Not unexpectedly, the fair day on which the most high blood pressure readings were recorded was Senior Citizens Day, August 24. On that day 60% of those tested had blood pressure above 140/90: 64% of 262 men and 51% of 448 women. Each person with a high reading was retested at once.

Records were kept of test results, including the person's age, sex, admitted height and weight, and whether the person had ever been treated for hypertension. Weather conditions and crowd size was also noted each day. In preliminary checks, no correlation was noted between these two factors and blood pressure test results. □

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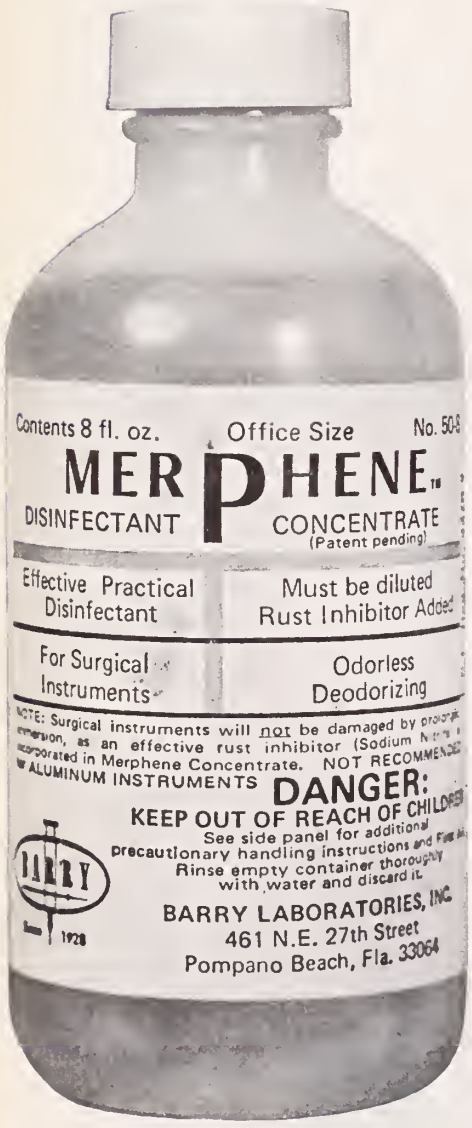

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NEWS HIGHLIGHTS

Wisconsin Neurosurgical Society Elects Officers

The newly formed Wisconsin Neurosurgical Society elected the following officers at its one-day meeting and scientific session held Sept. 15 at La Crosse Lutheran Hospital: president—David Ottensmeyer, MD,* Marshfield; president-elect—Byron Annis, MD,* La Crosse; vice-president—Fred Kriss, MD,* Madison; and secretary-treasurer—David Ostrow, MD,* Milwaukee.

Dr. Charles Drake, president of the Royal College of Surgeons—Canada and internationally recognized neurosurgeon, was the honored guest speaker at the state organizational meeting. The constitutional committee, headed by Dr. Byron Annis, neurosurgeon at the Gundersen Clinic, Ltd., La Crosse, presented a proposed constitution and bylaws for discussion; it subsequently was ratified by the 19 members present. Reports concerning incorporation and affiliation with the State Medical Society also were presented.

Other speakers included: A. Erik Gundersen, MD,* pediatric, thoracic, and cardiac surgeon, Gundersen Clinic; Doctor Annis; C. Norman Shealy, MD,* St. Francis Hospital, La Crosse; David Ottensmeyer, MD,* Marshfield Clinic, Marshfield; and MDs Glenn A. Meyer* and Robert Holst of Milwaukee.

This meeting was sponsored by the Adolf Gundersen Medical Foundation.

Teenager Medical Clinic Starts at UW Hospital

A general medical clinic designed for the needs of teenagers opened August 1 at University Hospitals in Madison. The clinic will comprehensively evaluate the medically and emotionally related problems of adolescence. It will be educationally oriented and directed toward a cooperative effort with the teenagers family physician or referring agency. Primary care also will be available on a limited basis. Staff for the clinic are John Stephenson, MD, assistant professor of pediatrics who is director of the clinic, John Anderson, MD, assistant professor of pyschiatry; Virginia Dykstal, RN, clinic nurse; Mary Denyes, nurse consultant; and Wendy Elliott, dietician. Patients will be seen on Wednesday mornings and all day Fridays.

Heart Association Allocates Record Amount for Heart Research

Forty-four Wisconsin scientists have been awarded a record amount of funds for 1973-1974 heart and circulatory research by the Wisconsin Heart Association (WHA), its president, John H. Morledge, MD* recently announced. The total of $338,766 for 44 grants and fellowships is the largest amount ever allotted for research by WHA. In announcing the grants Doctor Morledge explained that they are financed by the annual statewide WHA Heart Fund campaign.

Among the grantees are six members of the State Medical Society: John P. Kampine, MD,* Medical College of Wisconsin, who received $5,300 for research efforts in "Mechanoreceptors of the Left Heart and Coronary Arteries;" Prasanta K. Lahiri, MD, PhD,* MCW, $7,405, "Anti-arrhythmic Action of Quarterly B Blocking Agents;" Alfred Tector, MD,* MCW, $5,000, "A Detailed Study of Fibrous Hyperplasia in Vein Grafts;" P. S. Chopra, MD,* University of Wisconsin-Madison, $9,240, "Chronic Partial Cardiopulmonary Bypass;" George G. Rowe, MD,* UW-Madison, $10,463, "A Study of Coronary Artery Disease;" and Jefferson F. Ray, III, MD,* Marshfield Clinic Foundation, $5,232, "Glucose-Insulin-Potassium in Coronary Surgery in Man."

PHYSICIAN BRIEFS

Don G. Traul, MD*

. . . Monroe, recently became associated with the medical staff of the Monroe Clinic. He graduated from the Ohio State University Medical School followed by an internship at Ben Taub Charity Hospital, Houston, Tex. Doctor Traul served in the United States Army Medical Corps and was stationed in Viet Nam. He spent four years in general surgery residency, with the fifth and sixth year at the Cleveland Clinic, Ohio, as a staff member of the Department of Colon and Rectal Surgery. Doctor Traul is a 1971 recipient of the American Medical Association Physician Recognition Award. He is certified by the American Board of Colon and Rectal Surgery and the American Board of General Surgery.

Fredric S. Konz, MD*

. . . Stevens Point, is now associated with the medical staff of the Rice Clinic. He graduated from the University of Wisconsin Medical School and served his internship there. His residency was taken at the University of Texas Medical Branch, Galveston, and also at the University of Wisconsin. Prior to joining the Rice Clinic, Doctor Konz was associated with the Fond du Lac Clinic.

Paul S. Rosenfeld, MD

. . . assistant professor of medicine of the Medical College of Wisconsin, Milwaukee, became assistant dean for student affairs July 1. He has curtailed his research time in endocrinology service at the Veterans Administration Hospital, Wood, and in the department of medicine at the College in order to devote more attention to student affairs with special emphasis on admissions of minority students and curriculum reform. A 1969 graduate of the State University of New York, Downstate Medical Center, Doctor Rosenfeld joined the Medical College in 1969.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

L. Thomas Rozum, MD*

. . . Oshkosh, has joined the staff of the Oshkosh Clinic. Doctor Rozum graduated from the Medical College of Wisconsin and completed his residency in dermatology at University Hospitals in Madison.

Ashok K. Krishnaney, MD*

. . . Milwaukee, recently was certified as a Diplomate of the American Board of Anesthesiology.

Carlos C. Yu, MD

. . . New London, recently became associated with the Galang Clinic in New London. A graduate of the Far Eastern University in Manila, The Philippines, he served an internship at Mt. Sinai Hospital, Milwaukee, and residency at St. John's Hospital in Detroit. In Detroit, Doctor Yu was associated with Saratoge General Hospital, St. John's Hospital and the Maybury Clinic.

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Glenn A. Meyer, MD*

. . . Brookfield, recently was appointed to the faculty of The Medical College of Wisconsin as associate professor of surgery-neurosurgery. Doctor Meyer graduated from the University of Wisconsin Medical School and served his internship at Minneapolis General Hospital. His residency was completed at University Hospitals in Madison, where he then served on the surgical faculty of the University of Wisconsin. He entered the service of the United States Army Medical Corps and was appointed deputy director of the Department of Neurophysiology at Walter Reed Army Institute of Research, Washington, D.C. After completing his tour of duty, he served on the faculty of the University of Texas Medical School in Galveston for several years. Doctor Meyer will continue as chief investigator in an Atomic Energy Commission sponsored research contract to design, fabricate, and evaluate a device for the long-term measurement of intracranial pressure. He also is the associate editor of *Clinical Neurosurgery*.

David P. Kuter, MD*

. . . Baraboo, recently became associated with the staff of Medical Associates, Baraboo. He graduated from the University of Illinois School of Medicine in 1968 and interned at York Hospital, York, Pa. Doctor Kuter served in the field in Vietnam from 1969-71. He recently completed his family practice residency at University Hospitals, Madison, and was one of the first doctors in the new Family Practice Program.

G. John Weir, Jr., MD

. . . has joined the medical staff of the Marshfield Clinic in Marshfield. He is a graduate of the University of Colorado School of Medicine at Denver. He served on the staff of the Naval Hospitals at Portsmouth, Va., and Philadelphia, Pa., before receiving a master's degree in radiobiology from the University of Rochester School of Medicine and Dentistry. Recently he was on the staff of the Milwaukee County Hospital and the Medical College of Wisconsin. He is certified by the American Board of Internal Medicine and American Board of Nuclear Medicine.

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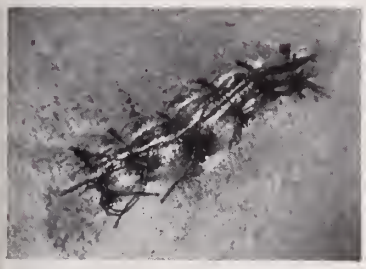

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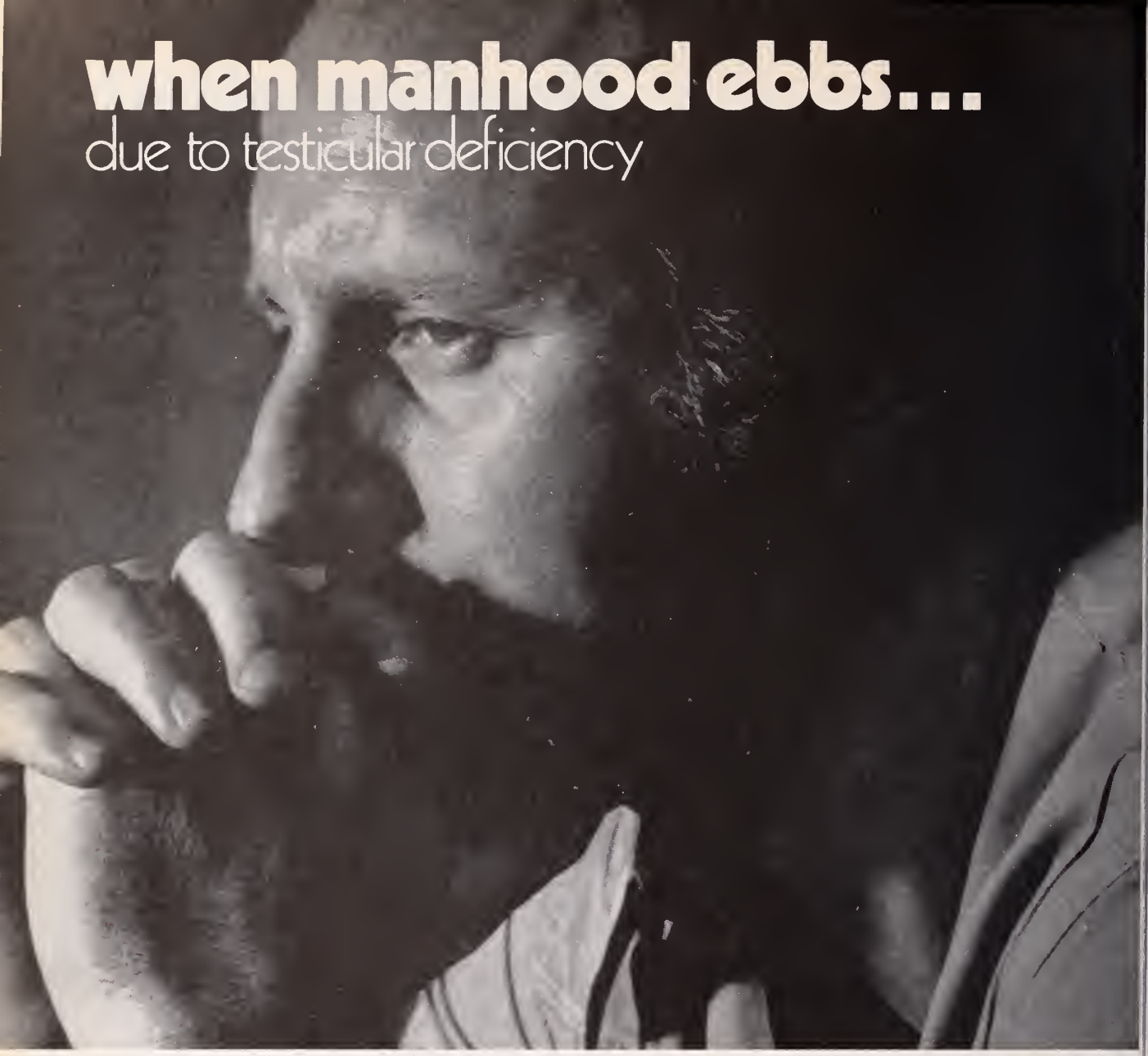

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Adverse Reactions: Acne. Decreased ejacu latory volume. Gynecomastia. Edema. Hype sensitivity, including skin manifestations an anaphylactoid reactions. Priapism. Hyperca cemia (especially in immobile patients on those with metastatic breast carcinoma). Viril zation in females. Cholestatic jaundice.

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2 mg—bottles of 100 scored tablets.
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For additional product information, see you Upjohn representative or consult the packag circular. J-3262-4 MED B-6-S (MA

*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 1 Beeson, P. B. and McDermott, W. eds. Philadelph W. B. Saunders Co., 1971, p. 1816.

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NEWS HIGHLIGHTS . . .

Wisconsin Surgical Society Has Fall Meeting

The Fall Meeting of the Wisconsin Surgical Society was held September 13-15 at the Gateway Hotel and Resort in Land O'Lakes. Principal speaker was Dr. Raleigh White, organizer and founder of the Scott-White Clinic in Temple, Tex. He presented a paper on his experience in group practice entitled "Group Practice—An Insider's View." He also participated in a round table discussion on group practice. Another guest was Mr. J. S. Loughridge, MD, FRCS of Belfast.

Twin Cities Medical Clinics to Merge

It was announced in July that the Riverside Clinic of Menasha and Twin City Clinic of Neenah will merge effective Jan. 1, 1974. Separate facilities will be maintained, however. Robert E. Dedmon, MD,* president of the Twin City Clinic, indicated that the merger would make access to medical care easier for residents of Neenah-Menasha and surrounding areas. Emphasis will be placed on in-depth availability of primary care for both adults and children, as well as consultation services. The merger will result in improved efficiency of medical manpower and of outpatient and ambulatory care, according to Fredric L. Hildebrand, MD,* Riverside Clinic president.

Kickapoo Valley Physicians Arrive

Two general practitioners, who have been assigned to the Kickapoo Valley by the National Health Service Corps to man clinics in LaFarge and Soldiers Grove for a two-year period, arrived in the Valley in July. They are MDs Dennis Nolan and Glen Golbus. Administration of the clinics is the responsibility of the Kickapoo Valley Medical Services Corporation, a nonprofit organization comprised of representatives from Kickapoo Valley municipalities. The KVMS Board has worked with representatives of the National Health Service Corps and with John Renner, MD,* head of Rural Family Practice in the department of medicine of the University of Wisconsin Medical School in Madison in setting up clinic operations. Doctor Golbus, who is practicing in LaFarge, completed his internship in June at the Milwaukee County General Hospital. Doctor Nolan is practicing in Soldiers Grove. He interned at a Portland, Ore., hospital.

Breast Cancer Detection Program Starts in Milwaukee

A $175,000 two-year program of early breast cancer detection was announced in early June by the Medical College of Wisconsin and Milwaukee County General Hospital. Sponsors hope to examine at least 10,000 women who show no signs of the disease during the two-year period. The program, one of 20 to be established in major American cities, is intended to reduce the cancer toll, demonstrate the usefulness of new diagnostic techniques, teach doctors and medical technicians, and seek to identify high-risk population groups. Money for the free program in Milwaukee is being provided by the National Cancer Institute, the American Cancer Society's national organization, and the Milwaukee Division of the ACS. It will be directed by James E. Youker, MD,* chairman of the Department of Radiology at MCW and the hospital, and John R. Milbrath, MD,* another member of the radiology faculty.

Condominium Medical Building in Wauwatosa Planned

Plans for a 10-story medical office condominium building in Wauwatosa, near Milwaukee County Institutions grounds and County General Hospital, were announced in July. The $4.7 million development will include eight floors of office suites and space for ancillary and supportive services. A feature of the building will be a "surgicenter," a surgical facility with operating rooms for outpatient or short stay operations. In addition to operating rooms, there will be laboratory, recovery room, sterile room, and other services. Arthur B. Py, Jr. and Thomas E. Vavra, III, are the architects and developers of the project. Marketing of the units will be handled by Wisconsin Investment Real Estate Co. □

PHYSICIAN BRIEFS . . .

Kenneth H. Rusch, MD*
Kenneth Kliese, MD

. . . Madison, recently joined the staff of the Counseling Center of Sauk, Juneau, and Richland Counties. Doctor Rusch has been with the Division of Mental Hygiene since 1961 and will continue as a consultant to the Division on major projects currently in progress. He is a graduate of the University of Michigan Medical School. Doctor Kliese graduated from the University of Wisconsin Medical School where he also served his internship and residency. He is in private practice at Madison Psychiatric Associates.

Domingo Hong, MD

. . . Grafton, recently joined the staff of the Grafton Medical Clinic. Doctor Hong graduated from Far Eastern University, Manila, The Philippines, and served his internship at Mt. Sinai Hospital, Milwaukee. His residency was at Veterans Administration Hospital, New Orleans, La., and in 1972 he returned to Mt. Sinai Medical Center, Milwaukee, on a fellowship. Doctor Hong also served as a clinical instructor at Tulane University, New Orleans, and preceptor at the Medical College of Wisconsin in Milwaukee.

Bernard C. Korbitz, MD*

. . . recently returned to Madison to become associated with the Dean Clinic. Doctor Korbitz is a 1960 graduate of the University of Wisconsin Medical School and was a member of the faculty. He has been in Denver, Colo., for two years serving as director of internal medicine at Presbyterian Medical Center and also serving as a member of the University of Colorado medical faculty.

James E. Willard, MD
Robert F. Burgfechtel, MD*

. . . Menomonie, recently have been elected to active membership in the American Academy of Family Physicians.

Howard M. Klopf, MD*

. . . Menomonee Falls, recently was appointed to the County Board of Health of Waukesha. He succeeds Jack R. Hoffman, MD* of Menomonee Falls.

Richard D. Larson, MD

. . . Ft. Atkinson, recently became associated with MDs Robert Handeyside* and Donald Bates* of Ft. Atkinson. He graduated from the University of Wisconsin Medical School and served his residency at University Hospitals. He was one of the first of two MDs to complete a family practice specialty in Wisconsin.

William N. Brandt, MD

. . . Janesville, recently joined the staff of the Janesville Riverview Clinic, Ltd. Doctor Brandt is a graduate of the University of Indiana School of Medicine and completed his internship at Duke University Medical Center, Durham, N.C. Doctor Brandt completed two years service with the United States Public Health Service and then returned to Duke University where he completed his residency in internal medicine.

Gustavo Gomez, MD

. . . Menomonee Falls, recently became associated with the staff of Medical Associates. Doctor Gomez attended medical school and served his internship in Bogota, Colombia. He served his residency in Milwaukee and received a fellowship in cardiology at the Medical College of Wisconsin, Milwaukee.

Willard Huibregtse, MD*

. . . Sheboygan, recently was honored on his 65th birthday for his many services to the communities of Oostburg, Cedar Grove, and Sheboygan. Doctor Huibregtse has been a member of the Sheboygan Clinic since his graduation from the University of Wisconsin Medical School in 1934.

M. E. Halac, MD

. . . Delavan, recently opened his office for practice at the Badger Medical Center. Doctor Halac completed his internship in Sioux Falls, S.D., and his residency in Cleveland, Ohio. He is a member of the Lakeland Hospital medical staff. Prior to moving to Delavan, Doctor Halac had practiced in Battle Creek, Mich.

Keith C. Bogart, MD*

. . . La Crosse, director of the electroencephalographic laboratories at Gundersen Clinic and St. Francis Hospital, recently was named president of the Wisconsin Neurological Society. Timothy K. Henke, MD* of the Department of Neurology Gundersen Clinic, was named secretary-treasurer.

Carroll Rund, MD

. . . Menomonie, recently joined the staff of the Red Cedar Clinic in the Department of Ophthalmology, to replace A. A. Drescher, MD* who retired. Doctor Rund

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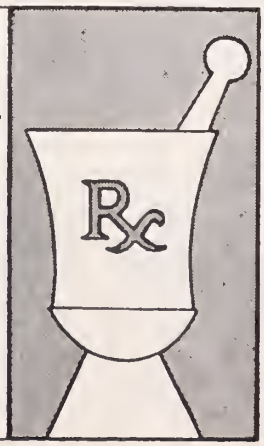

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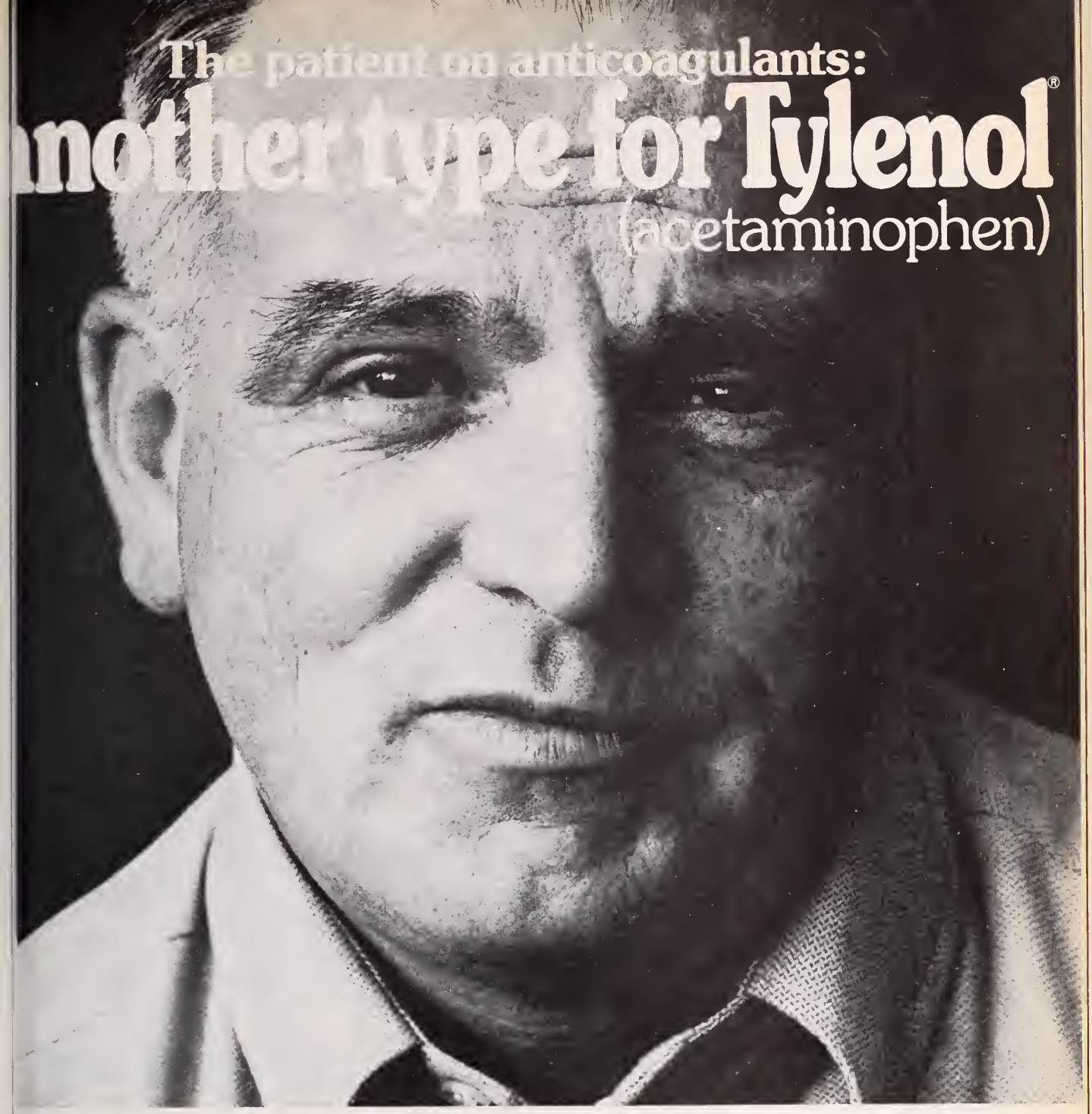

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quiring an analgesic, a new problem
ses. Aspirin frequently causes
olonged bleeding time and occult
strointestinal bleeding.[1,2]

TYLENOL (acetaminophen)
wever, is unlikely to produce either
action[2,3] and is therefore the
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morrhagic tendencies and
e patient receiving anticoagulant
erapy.

The patient on anticoagulants
only one of several 'types for
TYLENOL'-that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: **1.** Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. 285:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. 77:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. 282:1270 (May 28) 1970 (corresp.).

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

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graduated from the University of Minnesota Medical School and served his internship at St. Paul-Ramsey Hospital in Minnesota. He served with the United States Public Health Service in Detroit and then completed his residency at the University of Minnesota.

Raymond Witt, MD

. . . Evergreen Park, Ill., recently became associated with Hugh P. Rafferty, MD,* in the practice of obstetrics and gynecology in Kenosha. He graduated from the University of Illinois Medical School and completed his internship and residency at Milwaukee County Hospital. Doctor Witt is a junior fellow of the American College of Obstetricians and Gynecologists. He has been stationed at Naval Hospital Memphis, Tenn., for the past two years.

Duane L. Larson, MD

. . . a native of Stoughton, who now is chief of surgery for the Shriners Burn Institute, Galveston, Tex., has been selected "Physician of the Year" by the President's Committee on Employment of the Handicapped. Selection of the "Physician of the Year" is made annually in cooperation with the American Medical Association in recognition of the physicians who contribute outstanding effort toward the prevention of a crippling disease and the treatment and rehabilitation of patients suffering from that disease or handicap. Presentation of the award was to be made during a national AMA meeting at Philadelphia, Pa., September 18. A graduate of the University of Wisconsin Medical School, he served a rotating internship at the Medical College of Virginia and a general surgery residency at the University of Wisconsin.

Terry Hankey, MD

. . . recently won an award given annually by Mead Johnson Laboratories to outstanding medical residents in family practice of the country. More than 100 competed for the award, from the 1500 to 2000 residents in the nation who have enlisted in the family practice specialty. Doctor Hankey's award, one of 16 given, cited him for his scholastic achievement, interest and abilities in the medical specialty, and qualities of leadership. Doctor Hankey is a second year resident associated with the Verona Family Practice Clinic. He has been working with Dr. John Renner,* director of the Family Practice Program at the University of Wisconsin-Madison, on a health maintenance program.

Henry Goldberg, MD*

. . . Milwaukee, in August was appointed to the Medical College of Wisconsin Board of Trustees by Governor Patrick J. Lucey. As a condition of the release of state funds for the College, state law requires that one third of the members of the Board of Trustees shall be appointed by the Governor for staggered six-year terms, with the advice and consent of the Senate. Doctor Goldberg is director of the Goldberg Clinic in Milwaukee. He graduated from the Marquette University School of Medicine (now the Medical College of Wisconsin) in 1962 and was a resident in the Marquette Department of Surgery from 1963-64. Doctor Goldberg also served with the 18th Surgical Hospital at Quang Tri, South Vietnam.

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PHYSICIAN BRIEFS . . .

Chungki Lee, MD

. . . Hartford, recently became associated with MDs Wm. C. P. Hoffmann, Val V. Quandt,* I. H. Baie and Sr. S. K. Kim of the Hartford Clinic. A graduate of Seoul National University School of Medicine, Doctor Lee served as a medical officer in the Korean Army.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1973

4 Dane County Medical Society Board of Trustees
6 SMS Division on School Health
7 Medical Advisory Committee, Wisconsin Emergency Medical Services Program
10 Madison Surgical Society
12 SMS Commission on State Departments
13 Madison Academy of Internal Medicine
14 Ninth Councilor District, Wisconsin State Dental Society
17 Dane County Medical Society Insurance Advisory Committee
18 Dane County Medical Society Public Health Advisory Committee
19 Regional Advisory Group, Wisconsin Regional Medical Program
20 SMS Commission on Hospital Relations and Medical Education
21 Planning Committee, SMS Annual Meeting
24 Dane County Health Maintenance Program
25 SMS Commission on Safe Transportation
25 National Board Exams, University of Wisconsin Medical School
26 National Board Exams, University of Wisconsin Medical School
27 Executive Committee of SMS Council
27 Dane County Health Maintenance Program
27 Subcommittee of SMS Division on School Health on Conference of Physicians and Schools
29 SMS Commission on Medical Care Plans

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Rene S. Vicente, MD

. . . Wisconsin Rapids, has joined the Doctors Clinic as a general surgeon. He graduated from the Institute of Medicine, Far Eastern University, Manila, Philippines. Doctor Vicente served his internship at St. Luke's Hospital, Philippines, and Grant Hospital, Chicago. He completed four years of surgical residency at St. Joseph's Hospital, Chicago, and in his third year he was chief resident and served as a clinical instructor in surgery for Loyola University, St. Joseph's Hosptial, in his last year.

Joseph D. Motto, MD
Richard D. Kennedy, MD

. . . recently became associated with the medical staff of the Midelfort Clinic, Eau Claire. Doctor Motto graduated from Northwestern University Medical School and served a three-year residency at the Northwestern University Medical Center and completed a two-year advanced clinical residency in Gastroenterology at the Mayo Clinic. Doctor Kennedy graduated from the University of Minnesota Medical School and served an internship at the University of Utah Hospital, Salt Lake City, Utah. He completed a four-year residency in orthopedic surgery at the University of Minnesota.

Joseph L. Krueger, MD

. . . Madison, recently became associated with MDs George E. Oosterhous* and Robert B. Andrew* in the practice of ophthalmology. Doctor Krueger graduated from the University of Oklahoma School of Medicine in 1965 and served his internship and residency at the University of Missouri Medical Center.

Ralph J. Lumdgren, MD

. . . Oconomowoc, recently became associated with the Wilkinson Clinic. Doctor Lumdgren, formerly with the Milwaukee Health Department, is a graduate from the University of Cincinnati School of Medicine and served his internship at Milwaukee County General Hospital. He served in the United States Army Medical Corps from 1966-68 and recently completed his pediatric residency. Doctor Lumdgren will join MDs Peter B. Theobald* and Reza Amin at the Wilkinson Clinic.

John L. Melvin, MD

. . . professor at Ohio State University College of Medicine, has been appointed professor and chairman of the Medical College of Wisconsin's department of physical medicine and rehabilitation and medical director of the Curative Workshop of Milwaukee. Weston Gardner, MD, professor of anatomy at the Medical College, has filled the interim position of medical director at the Curative Workshop since July 1971 and will be available to assist Doctor Melvin. Robert W. Boyle, MD* has been chairman of the College's department of physical medicine since 1965. He will continue as director of the department of physical medicine and rehabilitation at the Milwaukee County Medical Complex. Doctor Melvin's professional interests include disability evaluation, health care delivery, neurophysiology, and electrodiagnosis. He has been teaching at Ohio University since 1964. As an associate professor of physical medicine he was largely instrumental in developing an effective program in physical medicine and rehabilitation at Ohio University.

Thomas Mengelt, MD

. . . Elwood, recently began the practice of medicine in Elwood. He graduated from Indiana University Medical School and served his internship at Ball Memorial Hospital, Muncie, Ind.

Leo Norden, MD

. . . Rhinelander, recently became associated with the Bump Medical Group, Rhinelander. Doctor Norden graduated from the University of Iowa Medical School and served his internship in Emanuel Hospital, Portland, Ore. He served with the United States Air Force Medical Corps in Kenai, Alaska, for two years. He recently completed his residency at the University of Iowa. □

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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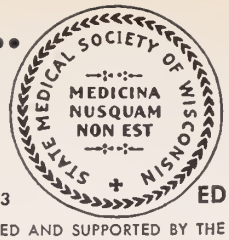
SECTION 

OPHTHALMOLOGY

OCTOBER 1973 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MOBILE EYE CARE UNIT

The Mobile Eye Care Committee met with its chairman, Walter E. Gager, MD, Waukesha, on Saturday, August 25, for a discussion of the development and costs of a possible statewide Mobile Eye Care Unit. The Wisconsin Lions Foundation has volunteered financial and manpower support.

* * *

A. The possible capabilities of a Mobile Eye Care Unit could be:
   (1) Glaucoma screening
   (2) Vision screening
   (3) Medical eye disease screening
   (4) Optical services
   (5) Educational
   (6) Speaker service
   (7) Data collection
   (8) Possibly an addition of audiometric screening.

B. The possible alternatives for some of the previously mentioned capabilities:
   (1) The financial support of one or more full-time staff people for the Wisconsin Society for the Prevention of Blindness to institute and work primarily with the Lions organizations and a local Lions Club for statewide screening and education, primarily glaucoma and vision.
   (2) Add the vision and glaucoma screening to the already existing multiphasic (State Department of Health and Social Services) mobile units which are already functioning about the state. This also would require Lions financial support and could be coordinated through the Wisconsin Society for the Prevention of Blindness.

   These two alternatives can provide the glaucoma and vision screening practically on location with utilization of volunteers and the local Lions Club at a reduced cost to the Lions Eye Foundation. However, if the remainder of the capabilities mentioned are desired, these cannot practically be provided in local geographic areas but would require a mobile eye unit with more highly trained personnel and sophisticated equipment.

C. Staffing of a possible eye unit could come from five possibilities:
   (1) Residents from Madison and Milwaukee
   (2) A local ophthalmologist
   (3) Local physicians
   (4) Registered nurses
   (5) Paramedical ophthalmic technicians

D. Conclusion:

   It was concluded by the Committee that the need for a Mobile Eye Care Unit in Wisconsin should be further explored. There appears to be a need for screening in the areas outlined. This conclusion was based on requests to the Wisconsin Society for the Prevention of Blindness for screening programs throughout the state, federal government investigation for possible future and mass screening program development, the interest of other state organizations in developing a like unit, and the need of ophthalmology involvement to insure the evolution of an appropriate, practical unit to accomplish the intended goals.

E. Recommendations:

   A meeting will be arranged to discuss these capabilities and recommendations with the Lions Eye Foundation.

LEGISLATIVE ACTIVITY

Elmer E. Johnson, MD, Madison, chairman of the State Medical Society's Legislative Committee of the Section on Ophthalmology, and Ed Lein, director of governmental affairs for the State Society, in mid-September appeared before the members of the Senate Health, Education, and Welfare Committee to express the Society's support for the passage of SB 503.

The proposal, if adopted, would create a dispensing opticians examining council under the Medical Examining Board. The council would grant rule-making authority to properly certified opticians.

As expected, the Wisconsin Optometric Association appeared in opposition to the bill with the statement that there was not strong public support for a measure of this type and that the legislation was not necessary. It is that Association's feeling that opticians should be controlled by the Optometric Examining Board.

Members of the Society were urged to contact members of the Senate Health, Education, and Welfare Committee and explain that this bill is needed in the interest of public eye safety.

In another public hearing by the Senate Judiciary and Insurance Committee on Assembly Bill 878, which would direct that the word physician when used in any accident and sickness policy include an optometrist, Doctors Johnson and James V. Bolger of Waukesha appeared in opposition to this legislation which would equate the services of optometry to those of a complete medical eye examination. AB 878 has already passed the Assembly and it is important that all Senators be contacted and told of the Society's opposition to this legislation which would tend to create confusion for the public. □

OBITUARIES

Ethan B. Pfefferkorn, MD, 77, Laguna Hills, Calif., died June 6, 1973 in Tustin, Calif.

Born on Aug. 8, 1895 in Marion, Wis., Doctor Pfefferkorn graduated from Washington University School of Medicine in St. Louis, Mo. in 1924. He served his internship at Mt. Sinai Hospital, Milwaukee, and his residency at Chicago Lying-In Hospital. Doctor Pfefferkorn served in the United States Army Medical Corps during World War I and also was a member of the American Legion. He established his medical practice in 1925 in Oshkosh and served as physician to the public schools from 1926-29. He was medical director of Sunny View Sanatorium from 1932-35 and assistant state health officer in 1936-37. Doctor Pfefferkorn joined the staff of University of Wisconsin-Oshkosh in 1935 and served as director of student health services until his retirement in 1965. After his retirement, Doctor Pfefferkorn spent a year practicing with his son, E. D. Pfefferkorn, MD, Colby, before moving to California.

He was a member of the Clark County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Elsie; a daughter, Mrs. Eugene (Dora Lou) Spanbauer, Oshkosh; and his son, E. D. Pfefferkorn, MD of Colby.

Conrad O. Rogne, MD, 84, Ettrick physician for more than 40 years, died July 5, 1973 in La Crosse.

Born on Dec. 9, 1888 in Madison, S.D., Doctor Rogne graduated from Rush Medical College, Chicago, in 1916. He served his internship at Presbyterian Hospital, Chicago, and also served in the United States Naval Medical Corps during World War I. Doctor Rogne had spent most of his physician years serving Ettrick with the exception of a year in Dubuque, Iowa, and Whitehall, Wis.

Doctor Rogne served for many years on the staff of St. Francis Hospital, La Crosse, and became an honorary member. In 1966, he became a member of the "50 Year Club" of the State Medical Society of Wisconsin.

He also was a member of the Trempealeau-Buffalo-Jackson County Medical Society and the American Medical Association.

Surviving are his widow, Charlotte; and three sons, Conrad, Jr., Ann Arbor, Mich.; Robert, Minneapolis, Minn.; and John, Madison, Wis.

Thomas L. Johnston, MD, 70, retired Milwaukee physician, died July 23, 1973 in Sheboygan.

Born on Oct. 23, 1902 in Winterset, Iowa, Doctor Johnston graduated from the Marquette University School of Medicine in 1929. He served his internship at St. Elizabeth Hospital, Appleton, and his residency at St. Luke's Hospital in Milwaukee. Doctor Johnston practiced in Milwaukee until 1971 when he retired and moved to the Town of Holland.

He served as attending physician for the Milwaukee Police Department for 20 years and was a doctor emeritus of the St. Luke's Hospital staff. During World War II, Doctor Johnston served in the South Pacific with the First Marine Division Medical Corps.

He was a member of the American Academy of Family Physicians, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Marjorie; a daughter, Mrs. Mark (May) Meissner, Alexandria, Va.; a stepdaughter, Mrs. James (Gene) Mohr, Spokane, Wash., and a stepson, Barton H. Schmidt, St. Paul, Minn. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF AUGUST 15, 1973

NEW MEMBERS

Adams, Albert H., 179 North 75th St., Milwaukee 53213
Frank, Albert R., 1300 University Ave., Madison 53706
Garcia, Larry S., 2145 Linden Ave., Madison 53704
Ghosh, Prabhakar C., 2900 West Oklahoma Ave., Milwaukee 53215
Gomez, Gustavo, 5004 North 106th St., Milwaukee 53225
Koh, Tong Chui, 11524 Watertown Plank Rd., Wauwatosa 53226
LaBreche, Michael J., 2453 Atwood Ave., Madison 53704
Mayhew, Duane G., 9094 North Lake Dr., Milwaukee 53217
Sandoval, Raynaldo G., 17155 West Mary Ross Dr., New Berlin 53151
Silbergleit, I. L., 5126 West Concordia, Milwaukee 53216
Terry, Daniel W., 12231 West Dearborn Ave., Wauwatosa 53226

CHANGE OF ADDRESS

Altenberg, Barry M., 1310 College Ave., Racine 53403
Austin, Stephen D., 704 South Webster, Green Bay 54302
Bardenwerper, H. W., Route #9, Box 538, Glen-Ray Heights, Salisbury, N. C. 28144
Baske, Richard F., Route #2, Oregon 53575
Bauman, Richard O., 8332 North Lake Dr., Milwaukee 53217
Beguin, Everett A., 1836 South Ave., La Crosse 54601
Desai, Jitendra N., 10875 San Fernando Rd., Pacoima, Calif. 91331
Dettmann, Norbert F., P. O. Box 4268, Milwaukee 53210
Frawley, Donald D., 9113 Lockland Court, Sun City, Ariz. 85351
Fry, Gerald L., Route #4, Box 238, Rutherfordton, S. C. 28139
Halbert, Helen E., 1601 — 1st St., West, Independence, Ia. 50644
Hanley, Larry L., P. O. Box 970, Eau Claire 54701
Henke, Samuel L., 1604 Drummond St., Eau Claire 54701
Hinck, Vincent C., Baylor College of Medicine, Houston, Tex. 77025
Jorris, Edwin H., 3315 Spring Hill Circle, Sarasota, Fla. 33580
Kagen, Louis, 1218 West Kilbourn Ave., Milwaukee 53233
Karzell, Ronald P., 500 West Milwaukee St., Janesville 53545
Malek, Gholam H., 30 South Henry St., Madison 53703
Matzke, Robert F., 1330 Sycamore, Janesville 53545
McGregor, William R., 731 — 46th St., South Great Falls, Mont. 59405
Millen, Francis J., 700 North Water St., Milwaukee 53233
Molsberry, Jasper M., 559 West Luebbe Lane, Milwaukee 53217
Odland, Paul K., 510 North Terrace St., Janesville 53545
Papadakes, N. G., 510 North Terrace St., Janesville 53545

continued on page 48

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85% in psoriasis *(150 of 177 patients)*[1]

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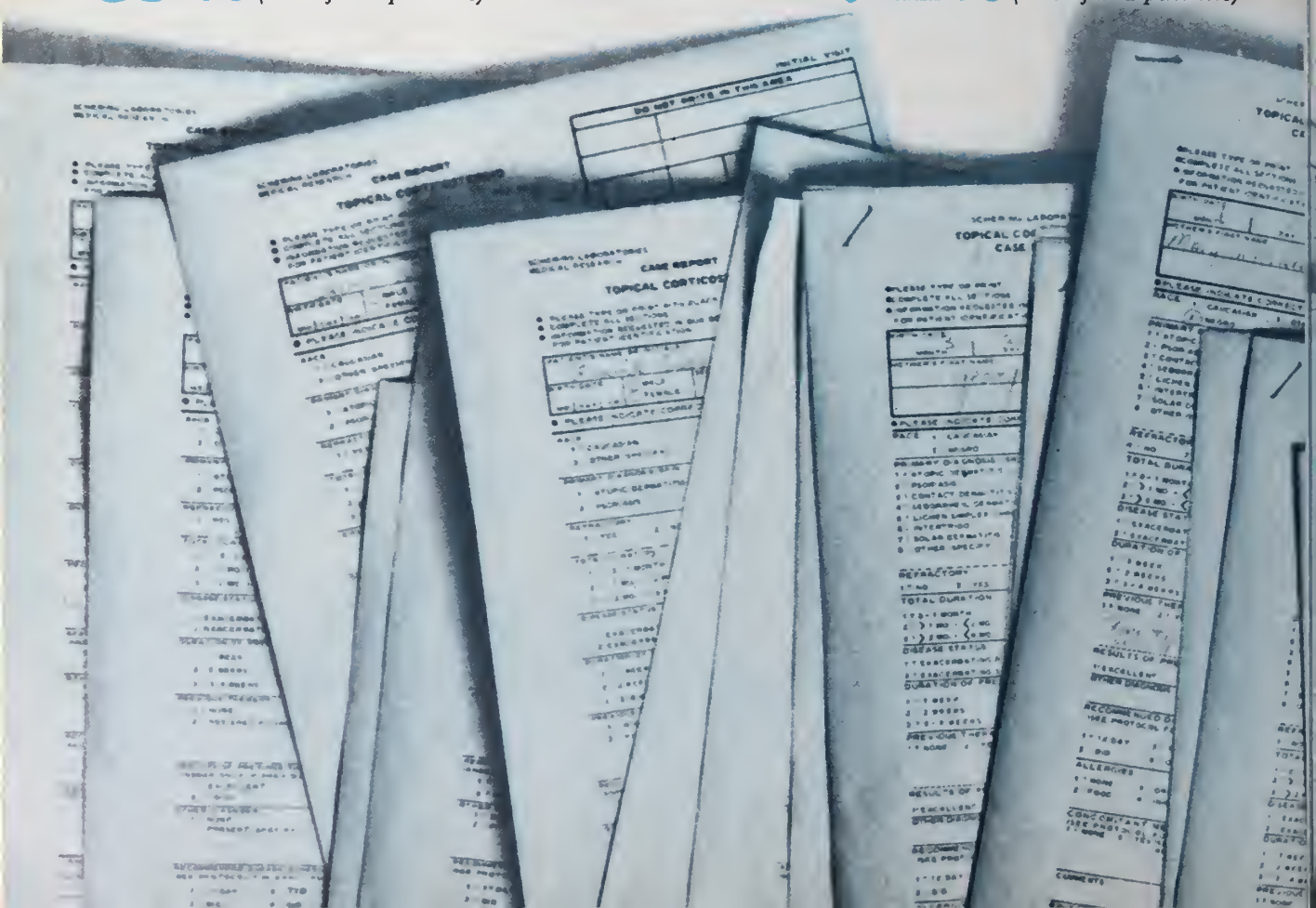

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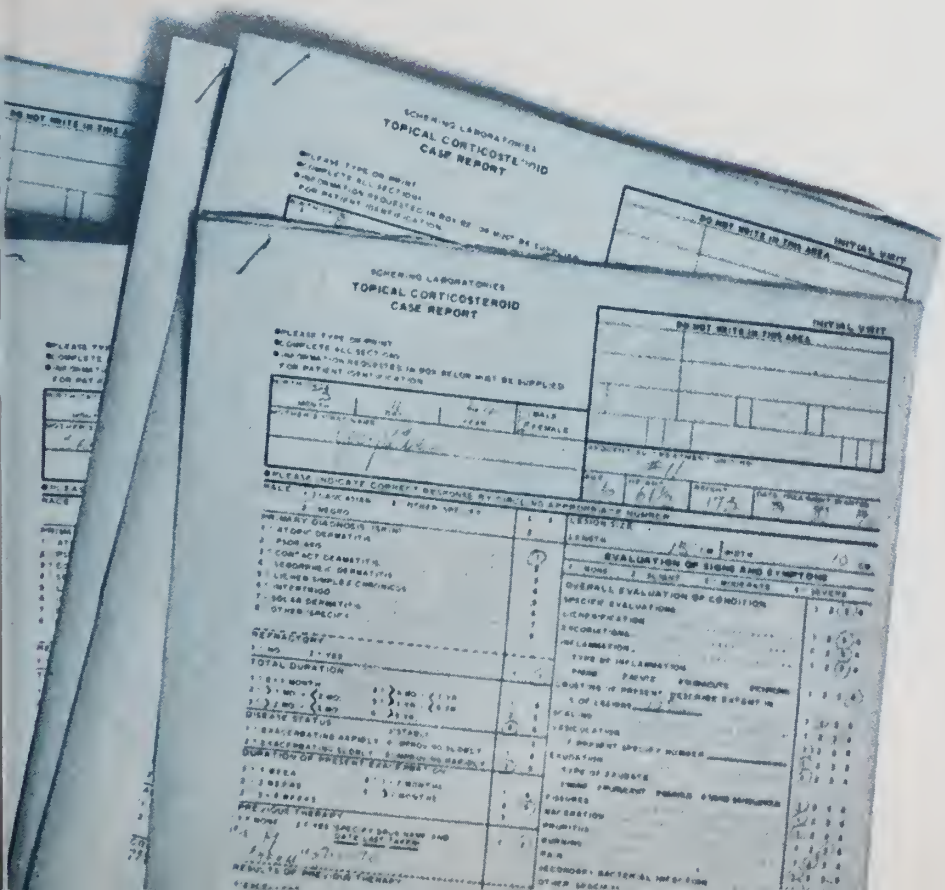

Schering

CLINICAL CONSIDERATIONS:
Description VALISONE products contain betamethasone valerate (9-fluoro-11$_\beta$,17,21-trihydroxy-16$_\beta$-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.
Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.
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For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

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Reigel, Donald H., 125 DeSoto St., Pittsburg, Pa. 15213
Rugowski, James A., Star Route, Spooner 54801
Ryan, Paul W., 34228 Venice Park Rd., Delafield 53018
Sandmire, Herbert F., 704 South Webster, Green Bay 54302
Sanfelippo, Michael L., D.O., 4600 North Wilshire Rd., Milwaukee 53211
Springer, Vincent G., 1404 Potatoe Point Rd., Appleton 54911
Stockland, Leo, 2711 West Wells St., Milwaukee 53233
Thomas, George L., 510 North Terrace St., Janesville 53545
Waisman, Raymond C., 6050 North Lake Dr., Milwaukee 53217
Wells, Marvin, 2040 W. Wisconsin Ave., 567 Bockl Bldg., Milwaukee 53233 (a change listed in the July issue, page 42, was incorrect)
Windeck, James L., 1030 Oak Ridge Dr., Eau Claire 54701
Wunsch, Charles A., 1445 South 32nd St., Milwaukee 53215

DEATHS

Epstein, Stephen, Dane County, June 30, 1973
Rogne, Conrad O., Trempealeau-Jackson-Buffalo County, July 5, 1973
Johnston, Thomas L., Milwaukee County, July 23, 1973 □

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MEDICAL YELLOW PAGES

DVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAIL-BLE, MEDICAL FACILITIES, and MISCELLANEOUS. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Addi-onal insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. BOXED AD RATES: 10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. EADLINE: Copy must be received by the first of the month preceding month of issue; e.g., copy for the August issue due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 57-6781.

YSICIANS EXCHANGE

EDIHC (MILITARY EXPERI- Directed Into Health Careers) is mployment referral and educational/ tional counseling service for veter- with military training and experience lied health occupations. A coopera- effort of DOD and HEW on the nal level, MEDIHC in Wisconsin onsored by the Wisconsin Health ncil, Inc., under a contract with the onal Institutes of Health. MEDIHC be of assistance to any employer of l health personnel in identifying po- al employees. For further informa- and a current listing of medically ed veterans seeking employment or further training related to their ary backgrounds, contact: Craig A. not, MEDIHC Coordinator, Wiscon- Health Council, Inc., 330 East Lake- Box 1109, Madison, Wis. 53701. 608/257–6781. 12tfn

ANTED: YOUNG BOARD CER- l or board eligible Obstetrician and ecologist to join three-man group h is part of a multi-specialty part- hip (40 physicians) in a rural Mid- community serving an area of ap- imately 250,000. Contact Dept. 394 are of the Journal. 5–10/73

ANTED: GENERAL PRACTI- ner to practice in new clinic just pleted. Excellent opportunity in a rt and recreational county seat com- ity. Ideal financial arrangements can nade. Contact Mayor Ken Bentley, ntello, Wis. 53949. 12tfn

NTERNIST: WANTED TO JOIN nulti-specialty group (internist, sur- n, ob-gyn, and GPs) in the "Home he Packers." Excellent school facil- and two universities. Excellent ern airport with connections all the country. New clinic building rds the ultimate in practice facilities one of our three modern, well- pped hospitals at the back door. ting salary of $30,000 with per- age bonus leading to partnership r one year; no buy-in required. For e complete information write or S. E. Milson, MD, Dousman Clinic, 5 Dousman St., Green Bay, Wis. 03. Tel: 414/494–9661 (phone col- l. 5–10/73

EDIATRICIAN WANTED TO JOIN ediatricians in suburban Milwaukee . Liberal salary first year. Apply: R. Guy, MD, Waukesha Pediatric oc., 1111 Delafield St., Waukesha, . 53186. 8-12/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY OF GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months. Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

WANTED: RECENTLY TRAINED radiologist to provide modern diagnostic and therapeutic radiological services for a recently consolidated midwest regional hospital of approximately 300 beds. Radiologist recently died and his part-time associate plans to retire soon. Contact Dept. 397 in care of the Journal. 9-10/73

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

WANTED: PHYSICIANS, SPECIALists or Generalists, who want to practice medicine in a semi-rural area but still have the advantages of the state's largest cultural, population, and medical center within twenty-five minutes travel.

Discover Ozaukee County. A beautiful blend of a rural agricultural setting interspersed with growing communities which are progressive but still preserve the charm and beauty of early Wisconsin history.

Physicians are urgently needed to provide the key that will open the health-care door for the 55,000 people who call this county their home. These people are more affluent than the average in Wisconsin. They need and want physicians to enjoy living and working in this area with all its advantages.

This is a prime recreation area on the shores of Lake Michigan, just north of the hustle and bustle of Milwaukee.

St. Alphonsus Hospital in Port Washington is an orderly, modern facility ready to provide acute, general hospital care in the heart of this county community. It is ideally located in the center of Ozaukee County about 20 miles from other hospitals to the north, south, and west. A new, 12-man office building connected to the hospital will be ready by August 1, 1973, and other office space is available in most of the nearby cities and villages.

If you are interested in the good life, and a good practice, contact George Seidenstricker at St. Alphonsus Hospital, 743 N. Montgomery Street, Port Washington, Wis. 53074. Tel: 414/284–5511. 6–10/73

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB-GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn/72

LAKE SUPERIOR CALLING WELL trained family practitioners, internists, pediatricians, otolaryngologist or urologist eager to practice where skills will be fully used and appreciated by the people living in Ashland and surrounding drawing area, 120,000 in all. Brand new 101-bed hospital with 5-bed ICU/CCU and extremely well equipped lab headed by full-time pathologist. Memorial Medical Center also has two full-time radiologists and complete range of x-ray facilities. Continuing education programs for medical, nursing and ancillary staffs. Other physicians practicing in Ashland: 3 ophthalmologists, 1 Ob-Gyn specialist, 1 psychiatrist, 1 internist, 1 new, busy general surgeon, and general practitioners. Progressive school system, new high school, vocational school and 4-year college. Need guarantee? A generous one is available. To arrange expense paid visit, write, sending CV to Fred Tidstrom, MD, 600 14th W., Ashland, Wis. 54806, or call collect after 6:00 pm, Ken Morrow, MD, 715/682-5321. 8-10/73

THE MONROE CLINIC IS INTERviewing Surgical and Medical Specialists to join the present 39 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical and Surgical Specialties:

1. Urology
2. Obstetrics and Gynecology
3. Orthopedic Surgery
4. Otolaryngology
5. Family Practice
6. Gastroenterology
7. Cardiology
8. General Internal Medicine

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 9tfn/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD, or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel. 608/339-3326. 6tfn/72

KROHN CLINIC, LTD., NEEDS physician interested in rural family practice. Group of six presently includes five ABFP plus board surgeon. Excellent situation for young physician, preferably not over 32, and desiring interesting variety in practice. New clinic building and new 70-bed hospital. Contact Wm. B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams St., Black River Falls, Wis. 54615, or call collect 715/284-4311. 10tfn/73

INTERNIST OR FAMILY PHYSIcian to practice in established clinic. Attractive city of 4000, plus surrounding area. Near Madison. 75-bed hospital with plans for expansion. Contact Dept. 399 in care of the Journal. 10-12/73, 1-3/74

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Family Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 10-12/73

IMMEDIATE VACANCY FOR staff physician at Grand Army Home for Veterans, King, Wis. 54946. Institutional geriatric practice of 700 patients, 4 full-time physicians on staff. Also have residency affiliation with the University of Wisconsin in Family Practices School of Medicine. Located in an excellent summer and winter recreational area, the Grand Army Home offers a challenging medical opportunity with the added benefits associated with small community living. Maximum starting salary for board certified physicians $30,204 per annum to increase to $33,292 per annum July 1, 1974. Fringe benefit program includes: liberal vacation plan, 9½ paid holidays, 13 days annual sick leave (which may be accumulated), a fully vested retirement program, low-cost health and accident insurance, income continuation insurance and other benefits. Please contact: John Peters, Personnel Manager. "An equal opportunity employer." 10/73

GENERAL PRACTITIONER wanted: Multi-specialty group practice in Milwaukee suburb. New clinic building. Excellent hospital nearby. Fine salary and benefit program. Contact: Mr. R. R. Grigg, 3533 East Ramsey Ave., Cudahy, Wis. 53110. 10-12/73

FAMILY PRACTICE OPENING January, 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreational opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, MD (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815. Tel: 509/782-1541. 9/73-8/74

ENJOY THE BEST OF TWO worlds! Discover Watertown, Wisconsin. No traffic congestion, smog, crime or other big city unpleasantness. Peaceful environment with new 100-bed general hospital and new connecting (but separate) medical office building. Good location to Madison and Milwaukee medical centers. Medical practice area includes over 40,000 people. Progressive community. New schools. Many parks, trees and recreational facilities. Stable economy. If you are a family practitioner, an internist, an orthopedist, and interested in a new solo or group private practice, write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261-4210. 10-12/73

EXCELLENT OPPORTUNITY: GI or FP for busy established incorporate practice in thriving community of 6800 Superior educational and recreationa facilities. Modern well-equipped clini adjacent 85-bed hospital. Starting salar open, partnership after one year. Phone visit, or write: C. E. Kozarek, MD, 32 Butts Ave., Tomah, Wis. 54660. Tel 608/372-4177. 10tfn/7

WANTED: GENERAL PRACTI tioner in city of Markesan, Green Lak County, Wis., to join two AAFP mem bers, so that we can all enjoy mor normal time for relaxation and famil life. Salary first year, partnership there after. Contact D. P. Cupery, MD Markesan Medical Center, P.O. Box 247 Markesan, Wis. 53946. 8-12/7

THE WAUSAU MEDICAL CENTEI (formerly Wausau Clinic), a famil medicine-multispecialty group of 4 physicians, is seeking the association o physicians in the following areas o practice:

1. General Surgery
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry
7. Family Medicine

First year salary open. Full membershi in two years. Fringe benefits includ retirement plan, medical and hospial in surance, life insurance. Excellent vaca tion and time-off plan. Metropolitan are of 50,000 adjacent to the finest vacatior area in the Midwest. Excellent genera hospital of 375 beds. For further infor mation write W. T. Becker, MD, Medica Director, Wausau Medical Center, 40 E. Thomas St., Wausau, Wis. 54401; o call collect: 715/842-0411. 10-12/7

LOCUM TENENS NEEDED IN two-man practice in Tomahawk, Wis. for one to two weeks between 12/19/7 and 1/9/74. Rotating work days allow for winter recreation time. Compensation very adequate. For further information call collect 715/453-2147. 10-11/7

LOCUM TENENS AVAILABLE A intermittent times doing family practice or emergency medicine. Contact Dept. 401 in care of the Journal. 10-11/73

INTERNIST—PEDIATRICIAN: 15 man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis. Tel.: 414/637-9271. 4tfn/72

GPs URGENTLY NEEDED TO JOIN a new four-man corporate practice located in central Wisconsin. Excellent recreational area, small town living within 40 minutes drive to Appleton and Green Bay. New fully equipped hospital and adjacent clinic facilities. Good salary, benefits with early equity. Excellent opportunity for sharing in growth development. Contact Dept. 398 in care of the Journal. 9-11/73

WISCONSIN MULTI-SPECIALTY roup of 17 physicians has openings 1 the following specialties: Internal Medicine, presently six men, general or ubspecialty training; Otolaryngology, resently one-man department; Allergy, n excellent opportunity as this specialty s not covered in our community. Attractive starting salary, no investment, orporate organization, exceptional pension and insurance programs, progressive ommunity of 45,000. Include curriculum vitae with correspondence. For urther information please contact Francis R. Russo, MD, Janesville Riverview Clinic Ltd., Box 551, Janesville, Wis. 53545. 9tfn/73

OPHTHALMOLOGIST RETIRING. Replacement needed. Excellent practice for 30 years. Clinic with parking, next o hospital. City 50,000. Great recreational area and schools. No investment. Contact Drs. Simones & Gallagher, 630 South 10th St., La Crosse, Wis. 54601. 10/73

IMMEDIATE OPENINGS FOR family practice, Ob/Gyn, pediatrics to join young expanding group. Wisconsin license or reciprocity. Top salary and fringe benefits. New clinic and excellent hospital facilities adjacent to clinic. Also solo practice available. New churches, schools, and outstanding outside recreational activities. Call collect, Les Hirt, Doctors for Medford, Medford, Wis. 54451. Tel: 715/748-4100 or 715/748-3726. 9-11/73

PRACTICES AVAILABLE

GENERAL PRACTICE AVAILable, lucrative—sudden death; large active practice in community of 35,000 with 50,000 population in area. Well equipped 8-room office; good for one or two MDs. Contact Attorney A. A. Muchin, 1004 Washington St., Manitowoc, Wis. 54220; tel. 414/682-7713. 8-10/73

GP NEEDED TO REPLACE DEceased MD in established practice. Entire inventory for sale, excellent hospital facilities, good school in resort and recreational area. SE Wisconsin. Contact Box 457, Williams Bay, Wis. 53191. g6tfn/73

PRACTICE FOR SALE: 30 MILES northwest of Milwaukee. Small town with access to new $4 million hospital and Milwaukee specialists. Retirement plans create this fine opportunity in a growing community. Combined residence and office plus adjoining lot for expansion. Call 414/629-5511. 8-10/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

LARGE PRACTICE AVAILABLE: Before you make any decison please see this practice. Good for two GPs. Do surgery, GP, OB-GYN. Well built and furnished practice. All recreation available right here with hospital in town. Contact Dept. 392 in care of the Journal. 8-10/73

MEDICAL FACILITIES

EXCELLENT OPPORTUNITY FOR pediatricians and internists to establish practice in beautiful new physicians condominium building adjacent to Bellin and St. Vincent hospitals in Green Bay, Wis. Patients immediately available on referral from other physicians in the building. Call or write H.F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748-3636. g4tfn/73

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn/72

FURNISHED OFFICE FOR RENT: Psychiatrist in part-time practice seeks mental health professional to share expense of attractively furnished and decorated two-room office, one of which doubles for conferences and group therapy. Ideally located in downtown Milwaukee with good parking facilities. Contact Dept. 400 in care of the Journal. 10/73

MISCELLANEOUS

GUIDELINES FOR BLOOD—ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

PUBLICATIONS

A Doctor Discusses Learning to Cope with Arthritis, Rheumatism and Gout. By Robert E. Dunbar, MSJ, Fellow, American Medical Writers Association, in consultation with Harold F. Seegall, MD. Published by Budlong Press Company, Chicago. Copies available to the public only through professional sources. Physicians interested in having copies available to their patients should contact: Mr. Larry R. Derzon, Milex Central, 1873 Grove St., Glenview, Ill. 60025; tel. 312/729-5353. 10/73

Speaking Out for Child Protection. By Vincent De Francis, JD, Director, Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 80201. Points to the urgent need for a more complete and thorough implementation of services on behalf of neglected and abused children. Speaks for a clearer mandate and for an earmarked source of funding. Content prepared in the context of testimony presented at a hearing before a United States Senate Subcommittee on a child abuse bill. Fifty cents per copy from The American Humane Association. (On all orders under $2.00 prepay by check, money order, cash, or stamps. All orders without remittance will be billed an additional 10% for postage and handling.) 10/73

A Doctor Discusses Learning How to Live with Heart Trouble. By Arthur J. Snider in consultation with I. J. Adatto, MD, attending staff and former director of the Coronary Care Unit, Lutheran General Hospital, Park Ridge, Ill. Published by Budlong Press Company, Chicago. Manual available to the public only through professional sources. Physicians interested in having copies available to their patients should contact: Mr. Larry R. Derzon, Milex Central, 1873 Grove St., Glenview, Ill. 60025; tel. 312/729-5353. 10/73

Utilization of Mental Health Resources by Persons Diagnosed with Schizophrenia (Series B, No. 3), released by the Biometry Branch of National Institute of Mental Health. Single copies of the report may be obtained from Public Inquiries, NIMH, Room 15C-17, 5600 Fishers Lane, Rockville, Md. 20852. 10/73

ANNOUNCEMENTS

THE AMERICAN SOCIETY OF LAW & MEDICINE, INC., the former Massachusetts Society of Law & Medicine, is now a national organization established for the purpose of acting as a catalyst to bring together for continuing educational purposes the disciplines of law, medicine, insurance, education and judiciary in a common meeting place for mutual understanding and exchange of information and ideas. For further information write or call national headquarters office at 454 Brookline Ave., Boston, Mass. 02215; tel. 617/734-8316.

FILMS

List of medical movies available from the American College of Radiology that all physicians may find useful in continuing education, self-evaluation programs, peer review studies, resident and intern training, etc. can be obtained by writing Charles Honaker, Director of Public Relations, ACR, 20 North Wacker Drive, Chicago, Ill. 60606; tel. 312/236-4963. 10/73

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1973 through Aug. 31, 1974 appeared in JAMA (Supplement) Aug. 13, 1973.*

1973 WISCONSIN

Nov. 3: The Transition of Life—The Obstetrician, Pediatrician, Community Hospital, and Medical Center, Lutheran Hospital of Milwaukee—Department of Obstetrics/Gynecology, at Herman L. Fritschel Memorial Auditorium, Milwaukee.

Nov. 3–4: Council Meeting, State Medical Society of Wisconsin, Madison.

Nov. 8: Genetic Manipulation of Man Symposium, University of Wisconsin-Stevens Point, Biology Department and Extended Services, Stevens Point.

Nov. 10: "Physician Extension Techniques" seminar sponsored by Marshfield Clinic Foundation for Medical Research and Education, at The Theater, University of Wisconsin, Wood County Center. Francis N. Lohrenz, MD, Chairman.

Nov. 10: Wisconsin Dermatological Society meeting, VA Hospital, Milwaukee.

Nov. 14: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Nov. 28-Dec. 1: Conference on the First Week of Life, sponsored by Wisconsin Association for Perinatal Care, Great Plains Organization for Perinatal Health Care, University of Wisconsin, Wisconsin State Department of Health and Social Services, and Division of Maternal and Child Health Services, at the Pioneer Inn, Oshkosh.

Dec. 6: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

1973 NEIGHBORING STATES

Nov. 2: Intensive workshops involving in-depth exploration of five topics: managing common skin problems, the problem-oriented medical record, what is new in stroke, vision workshop for the family physician, and seizures in childhood, at The University of Iowa Medical Center, Iowa City.

Nov. 3: Cancer program including discussions on the potential of immunotherapy for cancer, childhood leukemias, and progress in treating renal tumors, at The University of Iowa Medical Center, Iowa City.

Nov. 8-10: Chicago Medical Society's Postgraduate Course in Internal Medicine, at the Lake Tower Inn, Chicago. Info: Chicago Medical Society, 310 S. Michigan Ave., Chicago, Ill. 60604; tel. 312/922-0417.

Nov. 12-14: Pulmonary Disease: Clinical, Immunological and Pathological Correlations, American College of Physicians, Mayo Clinic, Rochester, Minn.

Nov. 12–17: Course in Laryngology and Bronchoesophagology, Dept of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 23–24: Conference on Radiology in Otolaryngology and Ophthalmology, Eye and Ear Infirmary of the University of Illinois Hospital, Chicago.

Nov. 28-30: Human Hypersensitivity Disorders: Clinical Aspects and Pathogenetic Mechanisms, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

Nov. 30: Surgery Conference involving epidemiology of large bowel cancer, surgical treatment of large bowel cancer, inflammatory diseases of the large bowel, and diagnosis of bleeding from the large bowel, at The University of Iowa Medical Center, Iowa City.

1973 OTHERS

Dec. 3-6: 10th Annual New Orleans International Postgraduate Course for Physicians on "Pulmonary Function in Health and Disease." Louisiana State University School of Medicine, New Orleans. Info: Louisiana Thoracic Society, Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130.

1973 AMA

Nov. 29-Dec. 1: AMA Board of Trustees, Anaheim, Calif.

Dec. 1–5: Clinical Convention, Anaheim, Calif.

1974 WISCONSIN

Jan. 9: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Feb. 2-3: Council Meeting, State Medical Society of Wisconsin, Madison.

Feb. 12-14: Wisconsin Academ Family Physicians Winter Confe Mt. Telemark, Cable.

Feb. 28: In-depth Teaching Pro State Medical Society of Wisc St. Marys Hospital Medical C Madison.

Mar. 25–26: Annual Scientific Pro State Medical Society of Wisc Milwaukee.

Mar. 25-26: Wisconsin Surgical S meeting in conjunction with Medical Society of Wisconsin A Meeting, program at Columbia pital and annual dinner at Perfo Arts Center, Milwaukee.

June 21-23: Wisconsin Academ Family Physicians Annual Me Abbey, Fontana.

Sept. 11-14: Wisconsin Society of nal Medicine meeting at Tele Lodge, Cable.

1974 NEIGHBORING

Mar. 18-21: Rheumatic Diseases: I genesis, Diagnosis and Treat American College of Physicians, versity of Michigan Medical C Ann Arbor, Mich.

Apr. 15-19: Clinical Endocrin Recent Advances in Diagnosis Treatment, American College of sicians, Mayo Clinic, Rochester,

May 19-31: Cardiac Auscultation, ican College of Physicians, Clinic, Rochester, Minn.

June 10-12: New Diagnostic and peutic Modalities in Internal Me American College of Physicians, versity of Iowa, Iowa City, Ia.

Oct. 6–10: Annual Meeting, Mi State Medical Society, Detroit.

1974 OTHERS

Jan. 22-24: 3rd Annual Pediatric monary Course, Louisiana State versity Medical Center, New O La. Info: W. Findley Raymond, Dir., A.L.A. of La., Inc., 33 Charles Ave., Suite 1504, Ne leans, La. 70130.

Jan. 26-Feb. 9: 15th Postgraduate cal Seminar Cruise, Dept. of graduate Medicine of Albany M College. Info: Frank M. Woolse MD, Department of Postgr Medicine, Albany Medical C Albany, N.Y. 12208.

May 3-17: 26th Annual Congres Teaching Seminar of the Interna Academy of Proctology, Montre Zurich, Switzerland. Info: Exe Offices, 147-41 Sanford Ave., Alfred J. Cantor, MD, Exec. Flushing, N.Y. 11355.

1975 WISCONSIN

Apr. 7-8: Annual Meeting, State cal Society of Wisconsin, Marc Hotel, Milwaukee.

☐ Copy deadline for MEDICAL MEETINGS is first of the month preceding the month of publication; e.g., copy for August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53

Clergy—Cancer—Concern. The American Cancer Society's Wisconsin Division and the State Medical Society's Committee on Medicine and Religion, are planning three clergy conferences this fall to more fully inform clergymen of the cancer problem.

Conferences will be held at St. Michael's Hospital, Stevens Point, Oct. 24; the Golden Rondelle Theatre, Racine, Nov. 13; and at St. Francis Hospital, La Crosse, Nov. 21.

Clergy conferences will include presentations entitled "The Cancer Problem," and "Why Should the Clergy Be Concerned?".

Program will include a physician speaking on the cancer problem, a clergyman giving his concerns of cancer as a health problem, a knowledgeable American Cancer Society volunteer relating the resources of this statewide organization, and a special focus speaker presenting the role of the clergy as a part of the medical team.

Reactor panels to the various presentations will kick-off discussion periods. A noon luncheon will be provided and all current ACS program materials will be on display.

Chairman for the Stevens Point Conference is Rabbi Ephraim Fischoff, Mount Sinai Congregation, Wausau.

Reverend Joseph Burke, Bethany United Methodist Church, Racine, is the chairman for the Racine Conference.

Hugh J. Uhrich, C. PP. S., Chaplain, Department of Pastoral Care, St. Francis Hospital, La Crosse, is the chairman for the La Crosse Conference.

These first-time special conferences for clergy are being held because of the numerous requests for them. Special consultant to the conferences is Reverend Perry Saito, Stevens Point, North Central District Superintendent of the Wisconsin Conference, United Methodist Church.

Additional information and registration can be obtained by writing to: The American Cancer Society, Wisconsin Division, Inc., P. O. Box 1626, Madison, Wis. 53701.

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin Extension/Madison 1973-1974

ON-CAMPUS CONFERENCES in Continuing Medical Education

Nov. 29-30: *Quality of Care Conference*

Jan. 25-26: *Exercise—As Therapeutic Tool*

Apr. 24-26: *Sports Education*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

The Transition of Life—The Obstetrician, Pediatrician, Community Hospital, and Medical Center. To be presented November 3 as an educational experience to all physicians by the Department of Obstetrics and Gynecology, Lutheran Hospital of Milwaukee at the Herman L. Fritschel Memorial Auditorium, Milwaukee, from 8 a.m. to 4:30 p.m.

In addition to local faculty, visiting participants will be Dr. Richard Paul, Assistant Professor, Perinatal Biology, University of Southern California, Los Angeles; Dr. Edward Makowski, Professor of Obstetrics and Gynecology, University of Colorado, Denver; and Dr. Stanley Graven, Co-director of the South-Central Perinatal Center, Madison.

Genetic Manipulation of Man Symposium. To be presented by the University of Wisconsin-Stevens Point Biology Department and Extended Services, Nov. 8 from 9 a.m. to 10 p.m.

Program highlights: "Scientific Possibilities for Genetic Manipulation of Man," by James F. Crow, PhD, Professor, Dept. of Genetics and Medical Genetics, UW-Madison; "New Scientific Genetic Techniques and Their Impact on Public Health," by Edwin Larkin, MD, MPH, Assistant State Health Officer, Division of Health, Dept. of Health and Social Services, Madison; "Genetic Counseling and Human Values," by Sheldon C. Reed, PhD, Director, Dight Institute for Human Genetics, and Professor, Dept. of Genetics, University of Minnesota, Minneapolis;

"Uses of Human Genetics in Clinical Pediatrics," by Jim Opitz, MD, Pediatrics and Neonatalecology, Dept. of Pediatrics, Marshfield Clinic, Marshfield; "Legal Aspects of Genetic Manipulation," by Alexander Capron, LLB, Assistant Professor of Law, The Law School, University of Pennsylvania-Philadelphia; "The Feminist Perceptive of Manipulation of Women (That Including Man), by Wilma Scott Heide, President, National Organization of Women; "Morality of Genetic and Reproductive Engineering," by Paul Ramsey, PhD, Harrington Paine Professor of Religion, Princeton University, Princeton; and

"Conflict Between Science and Humanists Views of Genetic Engineering," by Richard Hull, PhD, Assistant Professor, Dept. of Philosophy, State University of New York, Buffalo.

Registration: $3.00; box lunch, $1.40; dinner, $2.00; to: Division of Extended Services, UW-Stevens Point, Stevens Point, Wis. 54481.

State Medical Society of Wisconsin In-depth Teaching Programs: 1973-1974. Dates and locations for the programs are:

Wed., Nov. 14, 1973—Madison General Hospital

Thur., Dec. 6, 1973—St. Marys Hospital

Wed., Jan. 9, 1974—Madison General Hospital

Thurs., Feb. 28, 1974—St. Marys Hospital

Topics under consideration for presentation at the St. Marys group in December and February are: (1) Recent concepts and use of drugs in the management of congestive heart failure. Medical and surgical management of angina pectoris. (2) Current management of acid peptic disease, surgical and medical. Medical and surgical management of gallbladder disorders. (3) Update arthritis. Drugs used in the treatment of arthritis. (4) Management of common gram-positive infections—upper respiratory etc. Management of common gram-negative infections.

Topics for presentation at the Madison General group's November and January sessions are not yet finalized.

The University of Wisconsin Medical School will again participate by presenting the basic science applications and program for the various topics.

Further details will be announced as plans are formalized.

Special Nurse-Physician Team Project-UW Extension. Nurses and physicians from throughout Wisconsin will be able to participate in a special Nurse-Physician Team Project to be conducted by University of Wisconsin-Extension's Health Sciences Unit this fall.

The project is especially designed to update and extend the registered nurse's knowledge and skills in child care and to facilitate nurse-physician collaboration in delivery of primary care services to children. Nurses and physicians enter the program as professional teams and continue to work together after the program is completed.

Dr. Karen Pridham, director of the programs, said this will be the third year the project has been conducted but this year Extension hopes to increase the program's accessibility to nurses and physicians outside the Madison-Milwaukee areas.

The project had been funded by the Wisconsin Regional Medical Program, Inc. for the past two years but it did not receive federal funding for the project this year. Instead, Extension plans to continue the project from its budget. Dr. Pridham said it is hoped the project can soon be conducted on a partially tuition-supported basis.

This fall's program, however, will be tuition-free and will include 96 hours of classes for nurses over a four and a half month period—including supervised clinical work and independent study. Physicians will participate in on-campus seminars and work with nurses in local clinics to develop new work patterns.

Applications for the project are now being accepted for the fall. Nurses or physicians interested in participating in the program may obtain further information from Dr. Pridham at 1552 University Ave., Madison, (608) 262-0511 or from Dr. Marc Hanson, Medical Director of the program, same address, 262-0357.

Rehabilitation of Disabled People—The New Era. Fifth International Seminar and Exhibition will take place in The Central Hall Westminster, London, S.W.I., from July 1 to July 5, 1974. Particulars: Conference Secretary, REHAB, Tavistock House (South), Tavistock Square, London, WCIH 9LB, England.

MEDICAL MEETINGS . . .

Chicago Medical Society's Postgraduate Course in Internal Medicine will be held November 8-10 at the Lake Tower Inn, 600 N. Lake Shore Drive, Chicago, Ill.

The Course, which is presented annually, will be conducted by a panel of faculty members drawn from each of Chicago's six medical schools.

Traditionally, the Course, which is recognized for credit for American Medical Association Physician's Recognition Award, stresses various aspects of Internal Medicine—treatment, diagnosis, and followup.

This year's program will include Gastrointestinal and Liver Disease, Endocrinology, Arthritis and Pulmonary Disease, Cardiology, and Renal and Hypertensive Disease. Each of the six schools is responsible for a segment of the programming.

Fee for the three-day event is $125, including lunches and refreshments. Additional information is available by writing to the general offices of the Chicago Medical Society, 310 S. Michigan Avenue, Chicago, Ill. 60604. Dr. Richard L. Landau, professor of medicine, University of Chicago Pritzker School of Medicine, is chairman of the program committee for the Postgraduate Course.

A series of intensive workshops, a cancer teaching day and a conference on surgery of the large bowel will be held at The University of Iowa Medical Center in November.

The intensive workshops on Friday, Nov. 2, will involve in-depth exploration of five topics with an opportunity for practice of skills and much personal interaction with faculty members. Workshop topics will be managing common skin problems. the problem-oriented medical record, what is new in stroke, vision workshop for the family physician, and seizures in childhood.

The cancer program on Saturday, Nov. 3, will include discussions on the potential of immunotherapy for cancer, childhood leukemias, and progress in treating renal tumors. Physicians can bring their patients' problems for informal discussion at a series of case conferences.

Among topics at the surgery conference on Friday, Nov. 30, will be epidemiology of large bowel cancer, surgical treatment of large bowel cancer, inflammatory diseases of the large bowel, and diagnosis of bleeding from the large bowel.

Further info: Office of Continuing Medical Education, University of Iowa, 101 CMAB, Iowa City, Ia. 52242.

Thirteenth Congress of the Pan-Pacific Surgical Association. Feb. 15-21, 1975 at the Hilton Hawaiian Village Hotel in Honolulu, Hawaii. Concurrent meetings will be held in Anesthesiology, Colon and Anorectal Surgery, General Surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-Cardiovascular Surgery, and Urology. Details: Cesar B. DeJesus, MD, Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

American Society of Contemporary Medicine and Surgery 1974 Annual Meeting. Continuing education courses in all fields of medicine and surgery, accredited by the AMA. Certificates of participation in continuing medical education awarded. Feb. 10-16, 1974, Fontainebleau Hotel, Miami Beach, Fla. Early reservations at special convention rates. Info: Miss Virginia Kendall, ASCMS, 30 N. Michigan Ave., Room 1506, Chicago, Ill. 60602.

American Society of Contemporary Ophthalmology. Continuing education courses in all areas of ophthalmology, accredited by the AMA. Courses given by experts in microsurgery of the eye; lectures and small group discussions in cataract, glaucoma, diseases of the retina and cornea, strabismus, plastic surgery, soft lens, angiography, and other important topics. Certificates of participation in continuing medical education awarded. Feb. 10-16, 1974, Fontainebleau Hotel, Miami Beach, Fla. Earl reservations at special convention rates Info: Miss Virginia Kendall, ASCO, 3 N. Michigan Ave., Room 1506, Chicag Ill. 60602.

National Conference on Childhoo Cancer. Presented by American Cance Society, May 16-18, 1974, Fairmor Hotel, Dallas, Tex. Purpose of confe ence is to alert the medical communit to the progress being made in the diag nosis and treatment of childhood cance and to emphasize the need for earl diagnosis and the importance of prom treatment by a team of medical sp cialists and allied health personnel cap ble of rendering optimal care.

Sessions open to all members of th medical and related health profession Preregistration is requested. No registr tion fee. Program acceptable for: 1 Credit Hours in Category I for t Physicians Recognition Award of AM and 15 Elective Hours by the Americ Academy of Family Physicians.

Info: American Cancer Society, N tional Conference on Childhood Cance 219 East 42nd Street, New York, N 10017.

CONTRIBUTIONS—CES FOUNDATION
August 1973

The Charitable, Educational and Scientific Foundation of t State Medical Society of Wisconsin is grateful to Socie members, their various friends and associates, and oth organizations interested in the aims and purposes of the Fou dation, for their generous support. The Foundation wishes acknowledge the following contributions for August 1973:

Unrestricted

Wisconsin Physicians Service voluntary contribution
Woman's Auxiliary to SMS voluntary contributions
24 SMS members voluntary contributions

Restricted

2 SMS members voluntary contributions—*Student Loans*
1 SMS member voluntary contribution—*Charitable—Disabled Physicia*
NMC Projects, Inc.—*General Scholarship Fund*
Wiley-Smith Clinic, Fond du Lac; Neillsville Clinic; Memorial Hospit Inc., Neillsville—*Medical Student Summer Externship Program*
Mr. and Mrs. Wayne Brown—*Wisconsin Academy of Family Physicia Loan Fund*
Woman's Auxiliary to SMS—*Museum of Medical Progress (Sculpture)*
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BOOKSHELF

NEW BOOKS RECEIVED are ac-nowledged in this section. From these ooks, selections will be made for re-iews in the interest of the readers and s space permits. Reviews are written by nembers of the faculty of the University f Wisconsin Medical School and by thers who are particularly qualified. Most books here listed will be available n loan from the Medical Library Serv-ce, 1305 Linden Drive, Madison, Wis-onsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Functional Aids for the Mulitply Handi-apped. By Isabel P. Robinault, PhD. Medical Department, Harper & Row, Publishers, Hagerstown, Md. 1973. 256 pages. Price: $10.00

The Low Blood Sugar Cookbook. By Margo Blevin and Geri Ginder. Doubl-day & Company, Inc., 277 Park Ave., New York, N.Y. 10017. 1973. 518 pages. Price: $8.95

The Power and the Frailty. By Jean Hamburger. The Macmillan Company, 866 Third Ave., New York, N.Y. 10022. 1973. 140 pages. Price: $4.95

Lithium in Medicine. Edited by Joseph Mendels and Steven K. Secunda. 1972. Gordon & Breach, Science Publishers Ltd., 440 Park Avenue South, New York, N.Y. 10016. 221 pages. Price: $12.50

Human Reproduction: Conception and Contraception. By E.S.E. Hafez, PhD and T. N. Evans, MD. Medical Depart-ment, Harper & Row, Publishers, Hagers-town, Md. 1973. 778 pages. Price: $26.95

Principles of Clinical Electrocardiogra-phy. By Mervin J. Goldman, MD. Lange Medical Publications, Drawer L, Los Altos, Calif. 94022. 1973. 400 pages. Price: $8.00

The Structure of Medical Terms. By Verlee E. Gross. Halls of Ivy Press, 13050 Raymer Street, North Hollywood, Calif., 91605. 1973. 202 pages. Price: $7.50

Illustrated Programmed Gross Anatomy. By Verlee E. Gross. Halls of Ivy Press, 13050 Raymer Street, North Hollywood, Calif. 91605. 1973. 86 pages. Price: $10.00

Mastering Medical Terminology. By Verlee E. Gross. Halls of Ivy Press, 13050 Raymer Street, North Hollywood, Calif. 91605. 1973. 309 pages. Price: $10.00

Current Ethical Issues in Mental Health. National Institute of Mental Health, Mental Health Information, 5600 Fishers Lane, Rockville, Md. 20852. 1973. 55 pages

Values in Modern Medicine. By William Shainline Middleton, MD. University of Wisconsin Press, Box 1379, Madison, WI 53701. 1972. 299 pages. Price: $11.50

Correlative Neuroanatomy and Func-tional Neurology. By Joseph G. Chusid, MD. 15th Edition. Lange Medical Public-ations, Drawer L, Los Altos, Calif. 94022. 1973. 429 pages. Price: $8.50

Family Practice. Edited by Howard F. Conn, MD, Robert E. Rakel, MD, Thomas W. Johnson, MD. W. B. Saund-ers Co., West Washington Square, Phila-delphia, Pa. 19105. 1973. 1093 pages. Price: $29.50

Physician's Handbook. Seventeenth edi-tion. By Marcus A. Krupp, MD, Norman J. Sweet, MD, Ernest Jawetz, PhD, MD, Edward G. Biglieri, MD, and Robert L. Rose, MD. 1973. Lange Medical Pub-lications, Los Altos, Calif. 720 pages. Price: $6.50

The Impact, Costs and Consequences of Catastrophic Illness on Patients and Families. Cancer Care, Inc. and The National Cancer Foundation, Inc., 1 Park Ave., New York, NY 10016. March 1973. 59 pages.

Runaway House Handbook. National Institute of Mental Health, Center for Studies of Child and Family Health, 5600 Fishers Lane, Rockville, Md. 20852. 68 pages.

The Depressive Disorders—Special Re-port: 1973. U.S. Department of Health, Education and Welfare, National Insti-tute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. 57 pages. January 1973. Price: 75¢

Review of Physiological Chemistry. By Harold A. Harper. 14th Edition. 1973. Lange Medical Publications, Los Altos, Calif. 543 pages. Price: $8.50.

Current Concepts on Amphetamine Abuse. Edited by E. H. Ellinwood, MD and Sidney Cohen, MD. 1972. Super-intendent of Documents, US Govern-ment Printing Office, Washington, DC 20402. 238 pages. Price: $3.50

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BOOKSHELF . . .

Seeing and the Eye. By G. Hugh Begbie. Doubleday & Company, Inc., 245 Park Ave., New York, NY 10017. 1973. 227 pages. Price: $2.95

Dr. Thompson's New Way for You to Cure Your Aching Back. By Jess Stearn. Publicity Department, Doubleday & Company, Inc., 277 Park Ave., New York, NY 10017. 1973. 203 pages. Price: $7.95

The Second World Conference on Smoking and Health. Edited by Robert G. Richardson. Pitman Publishing Corp., 6 East 43 St., New York, NY 10017. 1973. 237 pages. $5.50

The First Five Years. By Virginia E. Pomeranz, MD with Dodi Schultz. Publicity Department, Doubleday & Company, Inc., 277 Park Ave., New York, NY 10017. 1973. 248 pages. Price: $6.95

Recent Advances in Therapeutic Diets. Compiled by staff of the Dept. of Nutrition, University Hospitals, University of Iowa, Iowa City. The Iowa State University Press, Ames, Iowa 50010. 1971. 174 pages. Price: $6.95

BOOK REVIEWS

Current Diagnosis and Treatment

By Marcus A. Krupp, MD and Milton J. Chatton, MD. Lange Medical Publications, Los Altos, Calif., 1972. Pages 962. Price: $11.00

The physician seeking "instant education" on almost any aspect of medicine which may be encountered in this country is unlikely to be disappointed if he consults this volume. Succinct writing and apparent careful editing has made possible the inclusion of a tremendous number of subjects in a relatively small volume. The authors are knowledgeable and objective in their presentations. Limited but quite helpful clinical descriptions are offered and pathologic physiology is included in an effort to permit intelligent utilization of the diagnostic and therapeutic data which is tabulated. A carefully selected bibliography follows most discussions and is usually quite current, while still selecting articles which have withstood critical scrutiny. Indexing is excellent so that quick access to the information sought is usually possible. Most practicing physicians would find this book quite useful were they to keep it available in their offices. —J. LeRoy Sims, MD

Malnutrition: Its Causation and Control.

Vol. 2, 1972. By John R. K. Robson. Gordon and Breach Science Publishers, Inc., 440 Park Ave., New York, NY 10016. 613 pages.

Volume Two of this title is a companion volume to Volume One of this edition. In the preceding volume, problems of global malnutrition, ecology, and the etiology of malnutrition are discussed along with the many aspects of normal nutrition.

The four chapters in this book contain in-depth discussions of human nutrient requirements (and recommended intakes), assessment of nutritional status, nutrition programs and services, and cultural determinants of food habits.

Nutritionists and dietitians engaged in applied nutrition programs should welcome this edition. Physicians should find it useful because of its extensive interpretation of human nutritional assessment and the appropriate measures to combat suspected malnutrition in population groups.

Chapter One presents a sound approach to the definition of nutrient requirements: "minimum;" "average;" and "optimal." These terms often are used loosely, and few individuals understand the significance of meaning as is presented in this text. This chapter also includes an excellent review of the concept of dietary nutrient interrelationships. Among the many ideas suggested here is the effect of limiting or excluding one or more dietary nutrients upon the requirement, absorption and/or utilization of other dietary nutrients. This concept has considerable clinical importance, especially in the prescription of modified diets for long-term usage. Recommended daily nutrient intakes for Americans, for residents of Canada and of the United Kingdom are listed.

The chapter on the assessment of nutritional status outlines the epidemiological approach to assessment of nutritional status of individuals and communities. It contains excellent information pertaining to the determination of nutritional status in large sample (field) surveys. It includes numerous references to the "limitations" of biochemical assessment of nutritional status and, as such, will be useful to the individual practicing physician. Information on growth patterns in normal and malnourished children also will be of value.

Means of organizing community programs designed to measure and treat malnutrition are discussed in the last section of the book. This material will be of special use to those in agricultural colleges who are actively engaged in field work abroad. The problems of underdeveloped countries, their farm and food production, and subsequent malnutrition are described clearly and visually. This material gives a structural and organizational format for ministries and health and social service agencies both abroad and in the United States.

Approaches to changing food habits, sections on food enrichment, food additives, and the special sections on the nutritional needs of the pregnant woman, the growing child, the obese adult, and the senior citizen, all contribute to the comprehensiveness of this book.

The theme of this book is malnutrition, national and worldwide. This nutrition textbook is truly unusual in its function of bringing into sharp perspective the many factors responsible for malnutrition. The sensible, realistic view of the various approaches to the detection and control of malnutrition should be appreciated by its readers.
— Annette Gormican, PhD □

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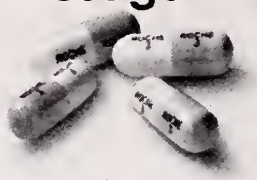

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Precautions: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

int Statement on Antisubstitution Laws and Regulations

The purpose of this statement is affirm the support of the participat- g organizations for the laws, regula- ns and professional traditions which ohibit the unauthorized substitution drug products.

Traditionally, physicians, den- ts and pharmacists have worked operatively to serve the best inter- ts of patients. Productive coopera- n has been achieved through utual respect as well as a common ncern for the ideals of public rvice. This mutual respect has been flected, in part, by joint support er the years for the adoption and forcement of laws and regulations ecifically prohibiting unauthorized bstitution and encouraging joint scussion and selection of the urce of supply of drug products. e basic principles of medical, den- l and pharmacy practice are thus ilized and preserved in the interest patient welfare.

The antisubstitution laws have t obstructed enhancement of the ofessional status of pharmacy any ore than they have in and of them- lves guaranteed absolute protec- n from unsafe drugs, or freed hysicians, dentists and pharmacists om their responsibilities to patients. s a practical matter, however, such ws and regulations encourage inter- rofessional communications regard- g drug product selection and assure ach profession the opportunity to xercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

P·M·A

ROCHE announces new BACTRIM™

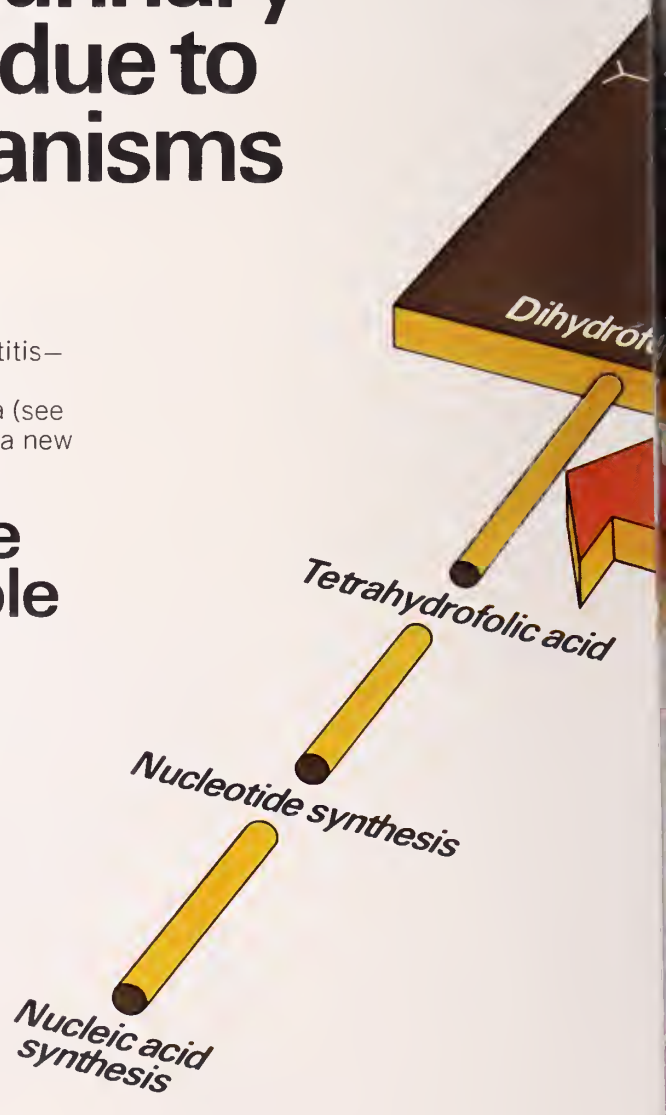
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis – when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.



ROCHE

new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

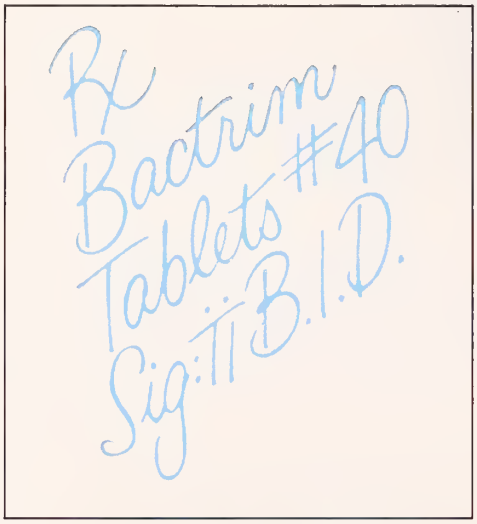
Contraindications: Hypersensitivity to trimethoprin or sulfonamides. Pregnancy and during the nursing period.

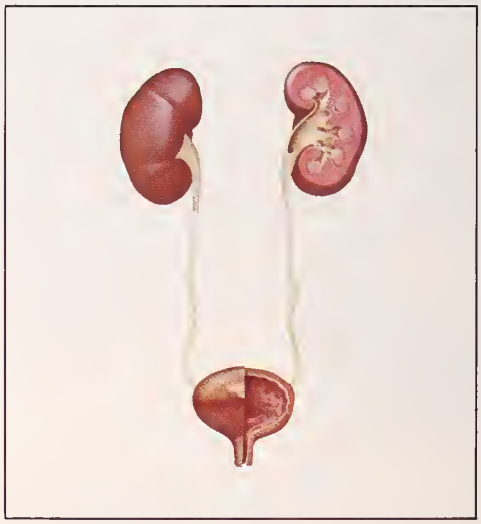
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrin should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.





new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

RAYMOND HEADLEE MD, Elm Grove—Editorial Director

Enfeoff—from the body politic

In this last of a series of three editorials, the effort will be to try to understand how the body politic exists in regard to its formal giving of medical responsibility. The individuals who are senators and representatives and governors and other directly elected persons constitute one facet of the body politic. Those persons who are not elected but who hold governmental positions of responsibility and authority in our civil system constitute a different sort entirely. Each must be considered in turn.

The elected persons, who after all decide the laws and the formal thrust of how things are done, are like specially tuned computers, who now and then exercise abstract judgment (idealizations?) but for the most part do not, indeed cannot, deviate very much from the public conception; e.g., of the role of physicians. Since they function as barometers of public opinion, they mostly reflect and only rarely lead.

For centuries the public has afforded to medicine, hence to organized medicine, the right to diagnose and to treat any condition that disturbs the "ease" of a human being, disease. Most political action, then, follows this sense of the public conception. Witness the slow and painful movement away from monarchy where for centuries the most daring political pressures towards democracy had to wait for the bulk of the people to stop giving power to Kings in the way they thought about Kings. Even in our own country, in 1776, a large portion of the populace thought monarchy! Similar examples are civil rights and medical care legislation, where the most avid politician could do nothing until the time was right. This does not mean right in any moral sense, but right as matching the popular view. The adept politician knows this and cannot run too far ahead, or too far behind, the popular demand. If he is not attuned he will simply lose the next election, unless he has particular charm. The elected bodies then represent what the electorate wants, or thinks it wants.

In regard to medicine, everybody wants care and cure and to be well looked after, yet may not be willing to pay the cost. Hence the great lag in public programs. Even cutting down the income of physicians, suggested by some, would only affect a small total saving of the cost of medicine, hospitals, and the like. Politicians today try to sense the will of the majority, to stay alive politically, or to soar to even higher posts.

It is interesting to note that polls are usually not sufficient indices of feelings about health concepts. This may be because health needs are difficult to assess, hard to visualize in yes-and-no question form, and still harder to conceptualize in fiscal settings. For the most part we retain the institutional rights to practice medicine; we are enfeoffed by our politicians to this extent. They cannot take away our right to diagnose and to prescribe and to treat, so long as the public so enfeoffs, even though some political individuals might so desire, and some lay pressure groups might try; e.g., friends of chiropractic, mega vitamine enthusiasts in California and New Jersey, and the like. We seem safe, for sometime to come, from this wing of the body politic.

But how safe are we from the non-elected but firmly entrenched, health-concerned government persons. Countless bureaus and sections exist which overlap and which exercise increasing control over what was once considered the province, the fief, of medicine. In treatment of alcoholism alone there are dozens of groups and systems that not only have medical people in primary positions (some for use in the immediate detoxification processes) but also in which medicine as a profession is definitely downgraded. The Governor's Task Force report, last year, felt physicians in general and psychiatrists in particular have failed to reach this particular disease and are not needed in overall diagnosis and treatment. In the area of drug addiction, research and management are handled by well over fifty separate federal agencies, each with funds and individuals paid to work in this area of disease, once enfeoffed to

physicians alone. Most are nonmedical; e.g., justice department, internal revenue service, and the like.

Several points are of concern to us as physicians: these political persons are not elected; they may be trained in medicine though more often they are trained in psychology, social work, or political science. Furthermore, they are free to impose their particular ideology upon all of us by the very direct and simple expediency of rules and regulations. These rules and regulations are derived from their own training and their own conception of what is medically best for the public. In no way can they be reached via public opinion, or even voting, except in the most general manner over decades. They can carry more effect on health policy than the most great sweeps of public sentiment. Now such individuals, with a few fortunately rare exceptions, are neither malicious nor stupid. But they march to their own inner drummer, or that of their immediate superior from whom their future flows, rather than depending upon the public or even that small group of men who daily meets with the problems of disease, the physician.

Some of us are gravely concerned about the first group, but others believe these people cannot get too far from reality, at least from reality as defined by what the public wants. Few physicians are concerned by the dangers from this second group of political persons, but many of us believe these persons to be the greatest danger. This danger stems not from some nefarious plot, but exists because the individuals are unchecked by any need to assess public feelings. Indeed they may consider themselves responsible to form that very public thinking as they see fit. Since this is so, their own abstractions and idealisms, left unchecked, can run in unexpected and sometimes dangerous directions.

As physicians in daily contact with many patients, we have an unparalleled opportunity to present clear and direct information, which in the long run will be the only way to deal with each of these political groups who so vitally affect our special enfeoffments. When we fail to perform well, or fail to understand the nature of our special position in the health world, we increase the chance for each group to seize upon these facts and create their own world, or fief, molding us as they desire, or without us. - RH

No Way!

RECENTLY IT WAS SUGGESTED that the AMA be petitioned by the State Medical Society requesting that the practice of selling the names and addresses of United States physicians be discontinued. There was particular concern about the sale of mailing lists to numerous publications including the throwaways. Further investigation reveals that there is simply no way in which this can be discontinued.

It is true that the annual revenue from the sale of such mailing lists to commercial mailing list houses results in an income in seven figures. It is the only up-to-date continuously current list of physicians in the United States. Because of this, all federal agencies use this list. The Internal Revenue Service and Justice Departments have indicated it would be restraint of trade if the AMA were to make available its mailing list to any one organization no matter how legitimate the purpose and not make it available equally and on similar terms to federal, state, and other agencies and to publishers of magazines so long as they follow the policies outlined in the AMA's Policy Manual for the use of the mailing list. Thus, the AMA cannot legally restrict the use of the list to a selected few individuals or organizations and not make it available to others.

The AMA does have a long-standing policy on making this mailing list available and has devised a stringent set of rules and regulations and terms under which it may be used by those who subscribe to the service.

There is one paragraph in the AMA policy governing the AMA's master list of physicians and medical students which may be helpful. This states that at the request of any physician or medical student the AMA will exclude his name and professional mailing address from the lists made available to outside parties. Of course, it would apply to any and all uses of the list and would result in complete exclusion of the individual unless he specifically wrote to individual journals or other agencies in which he might be specifically interested. — VSF

EDITOR'S NOTE: Some physicians also concerned about the influx of unwanted mail have indicated to the *Journal* that their method for stopping such material has been to write "refused" across the addressed area and return it to the Post Office. If the mailed piece has the imprinted statement: ADDRESS CORRECTION REQUESTED, the Post Office returns it to the sender who pays a 10¢ fee. After five or six such refusals, the sender finally takes their name off his list. □

HELP! HELP!

We desperately need a back issue of the *Wisconsin Medical Journal.*

Our supply of the **JULY 1973** issue is completely exhausted. If anyone has this copy available and does not require its retention for binding or other purposes, the Journal would appreciate having it sent to the Journal office or given to a State Medical Society regional representative.

Send to: Managing Editor (July 1973)
Wisconsin Medical Journal
Box 1109
Madison, Wis. 53701

No Sweat Savings.

Sometimes the hardest work of all is trying to save a few extra dollars. Those everyday necessities just seem to eat up your paycheck until there's nothing left to tuck away for the future.

But there is an easy way to build a nest egg. The Payroll Savings Plan. Just sign up where you work, and any amount you specify will be set aside from each paycheck and used to buy U.S. Savings Bonds. It's so simple, you almost forget your money's there working for you.

And, pretty soon, you'll be surprised at how your savings have grown.

The Payroll Savings Plan. Takes some of the perspiration out of planning ahead.

Take stock in America.

Bonds mature in less than six years.

Now E Bonds pay 5½% interest when held to maturity of 5 years, 10 months (4% the first year). Bonds are replaced if lost, stolen, or destroyed. When needed they can be cashed at your bank. Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS NOVEMBER 1973

Traveling Educational Symposia

THE AMERICAN ASSOCIATION of Medical Assistants has developed a plan to conduct four Traveling Educational Symposia for 1973-1974. Formerly a one-day Educational Symposium was held at the beginning of each year in one of the metropolitan areas. The Traveling Educational Symposia were developed to reach medical assistants in all parts of the state—both members and non-members.

The purpose of the Symposia are to make educational opportunities available to as many medical assistants throughout the state as possible. It is hoped that attendance at such a program will stimulate all medical assistants to continue educational endeavors. Secondary goals of the Traveling Educational Symposia are to stimulate and encourage our members to a more active status. Through exposure during the Symposia, it is anticipated non-member medical assistants will become interested in the American Association of Medical Assistants' ideals and goals. Additionally, we hope to gain favorable publicity for AAMA through the media and direct mailing.

The State has been divided into four sections using the State Medical Society's Councilor Districts as dividing boundaries. The four districts are: Rice Lake area (Districts 10, 11, 13), Appleton area (Districts 6, 8, 9), Waukesha area (Districts 1, 2, 5, 12), and Lake Delton area (Districts 3, 4, 7). To many medical assistants within these areas, this will be their only form of continuing education.

All medical assistants are invited to attend within the respective areas through a mailing to their physician-employer directed to the medical assistant's attention. Medical assistants from outside of the respective area may also attend at anytime. Mailings take place approximately one month prior to the meeting date.

The programs are held on Saturday to allow one full day of lectures and workshops as well as to minimize the time away from job responsibilities.

Variation within the program scheduling was of a great concern to the planning committee. They were concerned with continuing education for a loosely defined group—all medical assistants—but with numerous job functions; some with formal education, others trained on the job. The audience was anticipated to include receptionists, secretaries, bookkeepers, clerks, nurses, and technicians.

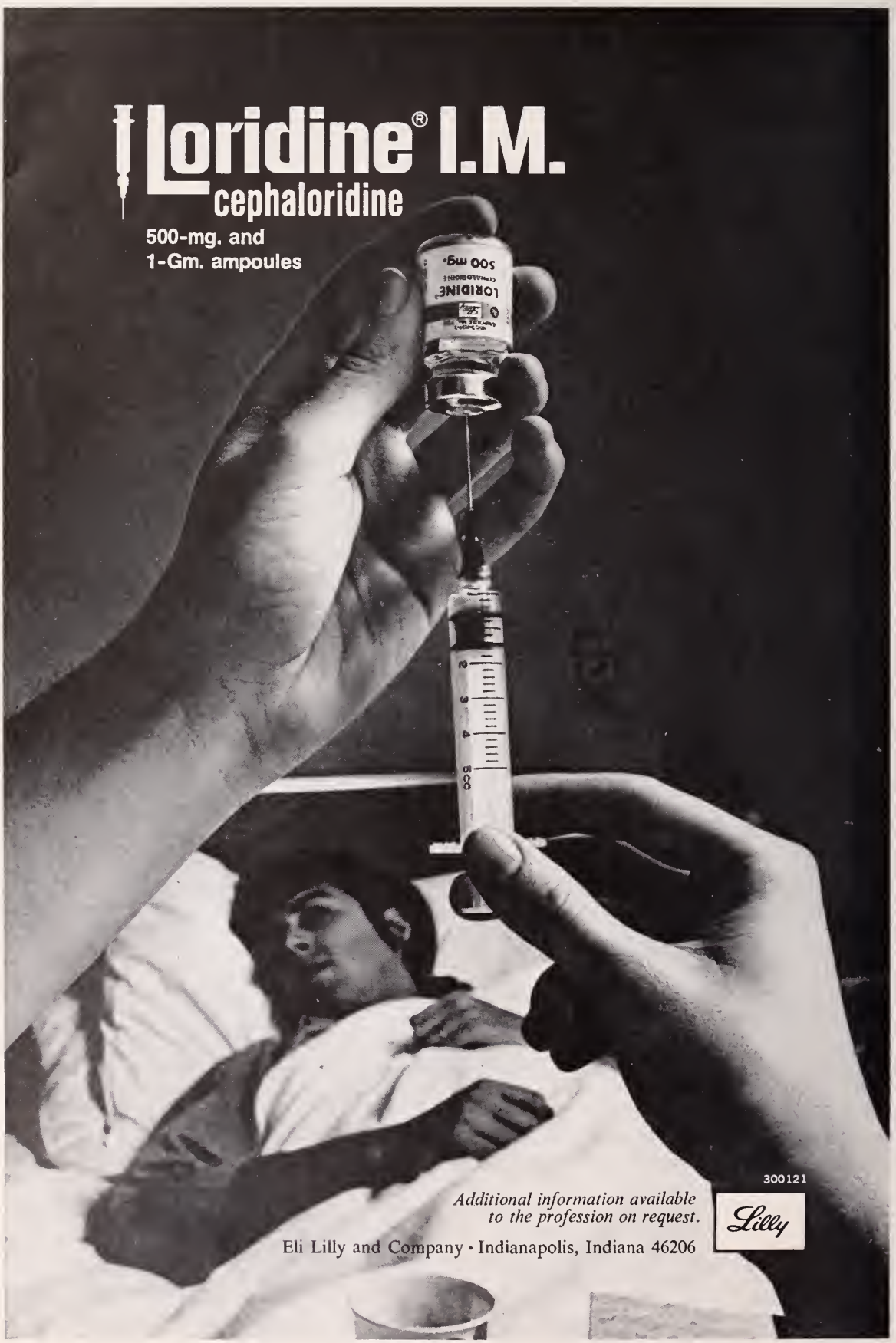
This year's program topics are: *Medical Law* which includes legal relationship of the doctor and patient, professional liabilities, the Doctor's public duties and liabilities and the medical assistant's liabilities. *Oral Communication* via the telephone, when making appointments, reception room techniques, and the attitude of the medical assistant toward the employer, fellow employees, and patient. *Sterilization Procedures in the Physician's Office,* its definition and method of as well as the care of sterilized items and equipment. And lastly, *Emergency Medical Services,* its definition and function of and the medical assistant's role in the program.

Each Traveling Educational Symposium should be self-supporting, but in certain areas of the state this will not be possible. The State Medical Society and Wisconsin Physicians Service have provided the printing, handling, and mailing of the program brochures and Surgical Care will be sponsoring the coffee breaks. Grants will be sought to take care of any unexpected expenditures.

The first of the four Symposia was held in Rice Lake on September 8, 1973. The remaining programs are scheduled for Appleton on November 10, 1973, Waukesha on January 12, 1974 and Lake Delton on March 9, 1974.

Those attending each Symposia are requested to complete the Evaluation Form provided by the committee. The comments and suggestions received from the Rice Lake Symposium were very enthusiastic and encouraging for future Symposia. Suggestions also were received for future Symposia topics which will be considered when scheduling topics for the 1974-75 Traveling Educational Symposia.

Doctors, you are urged to bring the above-mentioned programs and dates to the attention of your medical assistants and encourage their attendance. Registration information can be obtained by writing to the Traveling Educational Symposium Chairman, Mrs. Lucille Skolaski, 425 West Washington Avenue, Madison, WI 53703. □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WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 11 NOVEMBER 1973

JOSEPH M. KING *Festschrift* / PART I

▪ *Throughout your long tenure as head of The Department of Surgery at The Milwaukee County Hospital you added a unique dimension in teaching and inspiring us students, interns and resident physicians. The Marquette University School of Medicine was indeed blessed to have had on its faculty men of your breed who in your own quiet way instilled in us a love and pity for our less fortunate patients.*—ROBERT F. PURTELL, MD
Milwaukee

To Doctor King

WRITING AN ENCOMIUM for you is becoming a perennial pleasure. I was pleased to be asked to coordinate this festschrift issue in your honor. The response from faculty and former residents has been gratifying, a signal of the high regard in which you are held. This is especially noteworthy since they were given short notice and had to do their writing during the "hot summer days."

Among your publications I found an article on the treatment of Acute Empyema Thoracis which contains principles that hold true today although written in the pre-antibiotic era.

I have always envied your memory for names and for stories. It took me years to learn the "white horse" story. I do remember that you did the first pneumonectomy in Wisconsin which is not surprising considering your association with Dr. John L. Yates, a pioneer thoracic surgeon.

Another paper published in 1942 outlined principles for the treatment of the injured that are the battle cry of our present day trauma surgeons. Among your exhortations were:

Ambulance Transportation at *Sane* Speeds
Training of Ambulance Attendants
Proper Treatment of Wounds in the Field
Equipment for Treatment Enroute
Better Education in Trauma Care for All Physicians

I have in my possession a letter from Doctor Ellison documenting your role in procuring, for the use of the Division of Surgery, the building for the Allen Bradley Medical Science Research Laboratory.

Mrs. Brichta assures me that your interest and unselfish efforts were the major source of support for the development of the splendid medical library at Milwaukee County General Hospital.

I know from personal experience that we have a Coffey Auditorium and a King Conference Room to assist our educational efforts because of your foresight and administrative courage.

A prized perquisite of my house officer days is the fact that my surgical leinage can be traced from King to Yates to Halstead.

I have had the privilege of working with many courageous and dedicated surgeons but none have equaled your clinical acumen or your ability to impart wisdom. I owe you much for the opportunity to help in a small way to perpetuate a strong Division of Surgery at Milwaukee County General Hospital dedicated to good patient care and the education of young surgeons to serve the community.

Time has treated you kindly. I can think of no one more deserving.

—LEONARD W. WORMAN, MD, Milwaukee

Dr. Joseph M. King Man and Surgeon

EDWARD A. BACHHUBER, MD
Milwaukee, Wisconsin

I consider it a great honor to have been asked to contribute to this issue of the Wisconsin Medical Journal. *Dr. Joseph M. King and I have been close personal friends for thirty-six years. My original professional contact with him occurred during my internship at Milwaukee County General Hospital in 1937-1938. I am indebted to Doctor King's elder son, James, who furnished me details concerning his father's background and his early life.*

THE FOREBEARS OF Joseph Martin King came from County Clare, Ireland. His parents, Thomas King and Julia Byrd, were born on farms near Eden in Fond du Lac County, Wisconsin. They were the first couple to be married in St. Mary's Church in Eden. Farming was not for them. His mother was a school teacher and his father became a captain in the Milwaukee fire department.

On May 10, 1892, in a house in a German neighborhood on Iron Street in Bayview, Wisconsin, Joseph Martin King was born. He was the second oldest and the first son in a family of seven children.

After movement of the family from the south side, Joe attended both Holy Rosary and Gesu parochial schools. As the big brother in grade school, and with his father away as a fireman, Joe was called upon to do many household chores which he passed along to his younger brothers as they came of age. He was forced to become a man early in life.

He entered West Division High School and was a guard on a football team which possessed only twelve pair of shoes, necessitating an exchange of shoes in the event of a substitution.

While in high school, medicine was far from Joseph King's mind. His first choice of career was that of a naval officer, and he passed the examination for the U.S. Naval Academy at Annapolis. Poor eyesight prevented his matriculation. To help with family finances during this time, he worked as a fireman on a Milwaukee Road switchyard engine. He found other employment when a fellow fireman was scalded to death.

After graduation from high school in 1910, Joe King worked for Cohen and Abraham, wholesale liquor dealers in Milwaukee. Later he was an assistant manager for Cudahy Brothers, wholesale butchers, at that time in the third ward. Many of his great fund of wonderful stories came from his experiences during this period. He entered Marquette University in 1914.

Action outside the classroom was part of his life style, and it included service as team manager and as business manager for Marquette football teams. He recalls walking from the playing field at Ninth and State to the University with a full bag of receipts in one hand and a sash weight in the other.

Doctor King received his MD degree from the Marquette University School of Medicine in 1921 after completion of an internship at Milwaukee County General Hospital. His classmates included Francis D. Murphy, later Director of Medicine at Milwaukee County Hospital and Professor and Chairman of the Department of Medicine at the Medical School.

In a certain sense, the growth and development of Milwaukee County General Hospital paralleled that of Joseph M. King. His initial contact occurred in 1919 as an extern, and he functioned as a house officer because of the shortage of medical personnel. In April of 1921 he went to New York Lying-In Hospital for training in obstetrics and gynecology. He returned seven months later convinced that he really wanted to be a general surgeon, and he completed his training as the first house surgeon at Milwaukee County Hospital in 1924. During this period, one of his mentors was Dr. John L. Yates, who had been a resident of William S. Halsted at Johns Hopkins.

ALTHOUGH Doctor King ostensibly went into private practice in 1924 with Dr. F. D. Murphy (and later with Dr. Fred Stratton and Dr. Conde Conroy), his first love remained the care of the medically indigent at Milwaukee County Hospital. The acquisition of money never meant much to him. From 1924 until January 16, 1936, when he was appointed Director of Surgery on a part-time basis, he served as a volunteer. The patient load had increased, but the budget had not. On weekends and holidays when interns and residents were off duty, he worked for them. He was as concerned as his close friend, Dr. Harry W. Sargeant, hospital administrator, that patients received good care and that the hospital be run efficiently. He was also deeply concerned with the education and training of medical students. As Dr. Walter Zeit, Professor and Chairman, emeritus, of the Department of Anatomy at the Medical College of Wisconsin, aptly stated:

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"In those earlier days, without Doctor King and a few like him there would have been no supervised clinical training for senior medical students of the Marquette University School of Medicine."

This story is told of Col. Steve Sitter, M.C., U.S. Army (deceased). As he and a fellow student were sneaking out a door of the hospital early on an afternoon, he remarked, "I wonder where that damn Joe King is?" A tap on the shoulder, and a voice, "Here I am, Steve!"

Every medical school graduate from 1921-1962 had some contact with J. M. King. He had been a faculty member officially since 1928. At present, he is a Clinical Professor of Surgery, emeritus.

When Doctor King retired as Director of Surgery at Milwaukee County Hospital on May 31, 1962, he had trained 112 residents in general surgery who were at that time practicing in 30 different states, Puerto Rico, and five foreign countries. Thirty-eight of the surgeons practicing in the State of Wisconsin were sent forth by him, and one-third of the board certified surgeons in Milwaukee County were developed in his program. At present, many of his boys are on surgical faculties of medical schools.

THIS many-faceted man maintained a close association with Marquette University. He was team physician for the Athletic Department and a member of the Athletic Board from 1924-1948. He enjoys recalling the exploits of former Marquette greats. Track is his favorite sport, followed by baseball, football, and hockey. At one time he played golf, but he gave it up when he found it too frustrating. As a boy he had been a caddy.

Doctor King's numerous contributions were made possible through the patience, understanding, and stimulus of Irene Riordan King, a native of West Bend, Wisconsin, whom he first met as a medical student at the old Johnston Emergency Hospital. She is a graduate of the Marquette University School of Nursing and served as an officer in France in the U.S. Army Nurse Corps in World War I while Doctor King was an intern. It is stated that she still has over 700 letters he wrote during this period. Although he never proposed formally, he took for granted that she would marry him. She did on September 5, 1923. Their Golden Wedding was celebrated on September 5, 1973 with an anniversary Mass at St. Bernard's Church in Wauwatosa. The union produced two girls and four boys. At present there are 30 grandchildren, one of whom matriculated in the Medical College of Wisconsin in September, 1973. Another is enrolled as a premedical student. Daughter Mary is the wife of Mark O'Meara, a general surgeon in La Crosse; and Jane is married to James Guhl, an orthopedist in Milwaukee. Doctor King's brother, James, is a urologist in Milwaukee.

JOSEPH M. KING
Festschrift

WISCONSIN MEDICAL JOURNAL
November 1973/Part 1

I had the privilege of an internship, a residency in general surgery, and membership on the attending staff of the Milwaukee County Hospital during the time Doctor King was Director of Surgery.

My initial meeting with Doctor King occurred at a Dodge County Medical Society meeting at Mayville, Wisconsin, in the mid-thirties while I was still in medical school. I thought that here is a gruff, tough, well-disciplined man, a task-master who would not tolerate mediocrity. Such proved to be the case—he did not demand more of others than he constantly demanded of himself. He insisted that the intern and resident know his patient not only as a pathological entity but also as a person. He demanded that we be there for his early A.M. rounds, which included Saturday and Sunday. At times his temper flared in righteous anger, but then it would as rapidly subside.

The Chief had certain peeves and prejudices which included:

1. *Smoking, especially on wards or in nurses' stations.* According to rumor, he burned a hole in a new suit with a cigarette in 1940 and has not smoked since.
2. *Sitting on hospital beds by anyone.*
3. *Married house officers.* He thought that a wife and children interfered with the primary responsibility to patient and hospital. No "moon lighting" was allowed despite the fact that the intern made only $10.00 a month and the first year resident $50.00. With the socio-economic change following World War II, Doctor King became more tolerant.
4. *Interns and residents who failed to scrub on their cases.*

He too had failings. He was too self-effacing and humble. He did not write as he should. Personal correspondence was a chore, and to the despair of his secretary, many times his desk was piled high with unanswered correspondence. When questioned, he allowed that if he waited long enough it would not be necessary to do anything about it.

AS A CLINICAL teacher, Doctor King had no peer. His clinical judgment was uncanny. His performance of an abdomino-perineal resection was masterful. His patients loved him. He never compromised moral and ethical principles. His residents respected and admired him.

Doctor King survived with increase in stature a so-called "County Hospital Investigation" during the period December 7, 1945-March, 1946. A closer, more formal affiliation between the County Institutions and Marquette Medical School resulted.

In the planning of the last major addition to the Milwaukee County Hospital which was completed in 1957, Dr. J. M. King proved himself a man of great vision and foresightedness. Despite powerful opposition because of cost, he insisted on including the Coffey Memorial Auditorium, the fifth floor conference room (now the Joseph M. King Conference Room), a classroom in conjunction with each ward, teaching areas in the outpatient clinics, laboratory space, research areas, and a large operating room suite and recovery room. These are all musts for carrying on efficient medical and nursing education and good patient care. He anticipated the development of a medical center.

Doctor King is a founding member of the American Board of Surgery, a Fellow of the American College of Surgeons, a founder member and past president of the Wisconsin Surgical Society (1957), a charter member and past president of the Milwaukee Academy of Surgery, a senior member of the Milwaukee Surgical Society, and a member of the Wisconsin Surgical Travel Club. During World War II he held the rank of Lt. Commander in the Medical Corps of the U.S. Naval Reserve.

Doctor King is an avid reader and a history buff, especially when it concerns Wisconsin surgery and the Civil War. He enjoys biography and natural history. In earlier times, he and his wife attended many concerts and lectures and travelled widely.

Since retirement, Doctor King has not rested. Only recently he resigned from the Record and Tissue Committees at St. Joseph's Hospital. He is still doing things for others, attends scientific meetings, shops at the A&P, helps with housework and fulfills the responsibility he accepted at home, visits funeral parlors and helps bury his friends. He admits to difficulty with hips and one shoulder, but the spirit and the enjoyment and appreciation of life are still there.

According to his son, Jim, he is glad he got out of medicine when he did. He feels that for him life at the County Hospital has become too complicated and impersonal. However, he admires and appreciates the thrust for change brought about by superspecialization in the discipline of surgery and the utilization of modern, sophisticated monitoring equipment, mechanization and computerization. He feels very warmly toward and has been a staunch supporter of Doctors Edwin H. Ellison (deceased) and Jerome J. DeCosse, who succeeded him in the position he had held for over 27 years.

We thank Dr. Joseph M. King for a heritage that includes more than surgery. □

JOSEPH M. KING ***Festschrift***

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Integrity

The encomium that says it all.

All good surgical residency programs give their graduates a good foundation in the scientific facts that will make an individual an adequate surgeon. Good residency programs also give sufficient experience so that a trainee will come out of the program equipped to be technically proficient in surgical procedures. The most important ingredient of a surgical residency is not as easily measured as the two requirements mentioned above. This third ingredient is that of integrity.

Those of us who finished training under Doctor King were always certain of these three factors, particularly the latter. By example, we were taught what integrity meant. Without question, we knew that this meant a dedication to truth and morality. This meant that one would judge himself more harshly than he would his peers. This meant that he would have the courage to speak up when standards of surgical practice were not being met. This required the courage to express unpopular opinions. This required a clearheadedness to visualize truth without equivocation.

Those of us who knew Doctor King were certain of his word. We knew that if he said that a matter was to be decided in a certain fashion that this was what would be done. There was never any question as to what he meant. We knew the followup on his decisions would be forthright.

His loving relationship with his family and his devotion to his church are eloquent evidences of his moral integrity. His ethical relationship with other practitioners of medicine over the years was a constant guide for young surgeons.

An encomium should honor the person about whom it is written. I cannot honor Doctor King for he has done this for himself much more ably by the way in which he has lived his life.

I am immensely proud to have been "one of his boys."

—Henry F. Twelmeyer, MD, Wauwatosa

Carotid Artery Surgery for Cerebrovascular Disease

The Role of Emboli in the Pathogenesis of Transient Ischemic Attacks

LEONARD W. WORMAN, MD
Milwaukee, Wisconsin

JOSEPH M. KING
Festschrift

WISCONSIN MEDICAL JOURNAL
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Late in 1959 I started doing carotid endarterectomy for stenotic lesions in stroke patients at the Milwaukee County General Hospital. Dr. Joseph Mueller, whose experience as an attending staff surgeon counted in years equalled mine counted in months, gave me moral support and able assistance in the operating room.

One day, Dr. Joseph King, peering over my shoulder grunted, "What are you doing, Len?" I described the problem and the solution. Later in the hallway he said, "Ten years from now you are going to ask yourself, 'why did I ever do that operation?'" The studies reported below show his perspicacity. Our concepts of the role of surgery in stroke therapy have changed much since that time.

CAROTID ENDARTERECTOMY was initially conceived as a procedure to improve cerebral blood flow.[1,2] A stenosis of 50% or greater was shown[3] to cause a pressure gradient and presumably therefore a significant decrease in cerebral blood flow. Patients with various degrees of neurologic deficits were operated upon if they had demonstrable lesions in the carotid system.

The results of surgery on the first 16 patients reported in 1961 showed the progressive stroke patient not to benefit (Fig 1). However, when the collected series from Milwaukee County General Hospital was reported in May 1963, seven more patients had been added to the emergency surgery group. Again, it was suggested that such surgery was not indicated. In the same year, Bruetman et al[4] elucidated the pathophysiology that explains the poor results of restoring blood flow to the freshly infarcted brain.

On my service, the following routine was adopted early in the series. General endotracheal anesthesia assured a quiet patient during the crucial arteriorraphy. Patches were necessary only in exceptional circumstances. An internal polyethylene shunt was used unless rare technical difficulties prevented it. (This was continued in spite of later disenchantment with the significance of blood flow through a specific artery.) Systemic heparin was given just prior to clamping the vessel for arteriotomy. Because of postoperative hemorrhage, we soon began to reverse the heparin effect during the last stitches of the arteriorraphy.

In 1963, the collective experience was reported (Fig 3). Only 1 out of 3 patients appeared to be benefited by surgery. Nine patients with emboli led the group of 25 operative complications. Two case reports are illustrative of the problem.

Case Reports

CASE 1. A 37-year-old white male plumber was admitted to Milwaukee County General Hospital in 1960 with a left hemiparesis discovered when he tried to get out of bed that morning and fell. He denied any prior symptoms or ill health. An angiogram showed a large filling defect, which the radiologist called a thrombosis, just below the bifurcation of the right common carotid artery. The artery was exposed under local anesthesia.

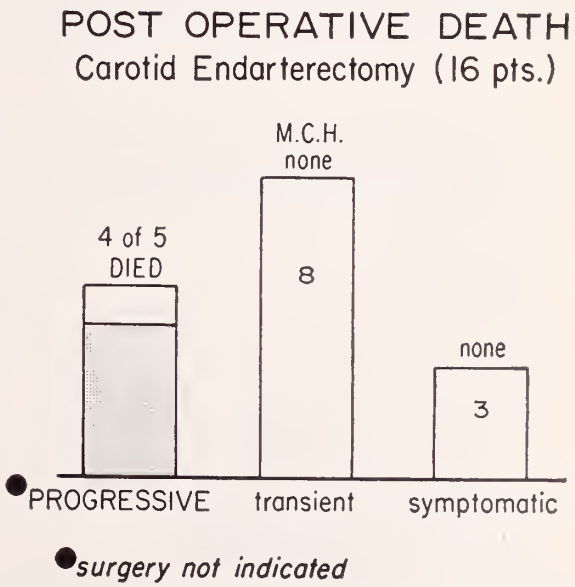

Figure 1—Results in first 16 patients in Milwaukee County General Hospital series—25% mortality rate; all in the progressive stroke group.

From the Division of Surgery, Medical College of Wisconsin, and the Milwaukee County General Hospital, Milwaukee, Wisconsin.
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The patient became confused and obstreperous. General endotracheal anesthesia was then employed. The intima was quite rough on the posterior wall of the artery with a *break in the intima containing a minute thrombus.* There must have been a larger thrombus which was dislodged.

The patient recovered from anesthesia slowly and when awake was found to have a worse paralysis from which he gradually improved to his preoperative state. His left arm is useless, but he walks with a leg brace and has shown no progression of his cerebrovascular disease in the 13 years since.

CASE 2. A 69-year-old white male was admitted to Milwaukee County General Hospital in 1961 because of weight loss and weakness. He had had multiple previous admissions for a variety of problems which included adult onset seizures recurring for 10 years and fainting followed by temporary hemiparesis of the left or right extremities at various times.

External compression of the right carotid artery produced coma in 10 to 15 seconds, suggesting a severe cerebral blood flow deficit. Bilateral carotid angiograms showed an "irregularity" at the right bifurcation without significant obstruction and an extensive irregularity and narrowing of the left common and internal carotid arteries in the region of the bifurcation.

At endarterectomy, the scar tissue around the left carotid bifurcation was dense and more extensive than usual. After much manipulation, the artery was opened and grumous material was noted in the atherosclerotic plaque. Postoperatively, the patient was comatose and a right hemiparesis was present. He cleared somewhat but a severe neurologic deficit persisted and the patient died of bronchopneumonia on the thirtieth day. At autopsy, there were multiple atheromatous emboli in the vicinity of multiple areas of encephalomalacia, "presumably, the result of a surgical manipulation of the carotid artery."

Discussion

Inquiry of several nationally known vascular surgeons in the next few months failed to uncover similar experiences. Nevertheless, a procedure was adopted to prevent such an occurrence again. The internal carotid artery was found first and a tape was looped about the artery so that it could be intermittently occluded while dissection was done around the bifurcation through the fibrous tissue that results from the inflammatory process in the region of the atheromatous plaque. Any dislodged debris would thus embolize only the external carotid system. Back bleeding, 100-150 ml from the internal carotid was used on the theory that it may wash out embolized atheromatous debris.

While alerted to the significance of emboli, we were still influenced by the flow theory. In 1962 and 1963 all patients having carotid artery surgery on my service had cerebral blood flow studies done by a variation of the Ketty technique. The spectrometry and computations were done by Dr. Warren Kempinski[5] and his associate, Dr. John Baker, from the Neurology Service. Before and after endarterectomy, Evan's blue dye was injected into the internal carotid artery and timed samples collected at intervals from the jugular bulb via a catheter placed through a branch of the internal jugular vein. We learned only that there was no correlation between blood flow so measured, the size of the lesion, and the clinical result.

The next effort included pressure studies and, with the cooperation of the Cardiology Department,* dye dilution curves pre- and post-endarterectomy. Figure 4 shows the abolition of a pressure gradient by carotid endarterectomy, but the dye dilution curves showed no significant change in flow. While this technique was more sensitive than the Evan's blue dye studies, we felt more specific measurements would prove that cerebral blood flow was improved by endarterectomy.

We then acquired a Carolina electromagnetic square wave flow meter which we used first in the

*Dr. James Botticelli.

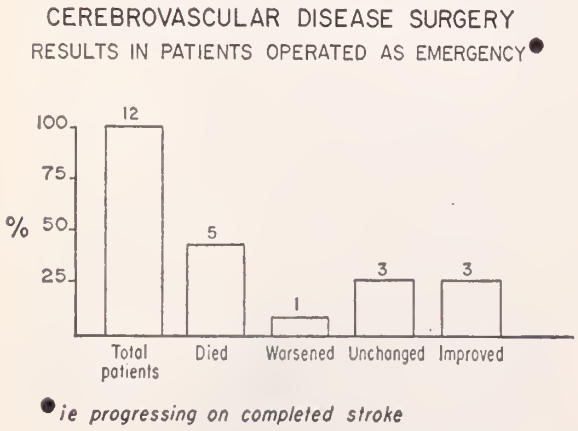

Figure 2—Analysis of results in the progressive stroke group from the expanded Milwaukee County General Hospital series reported in 1963. Seventy-five percent did not benefit from surgery.

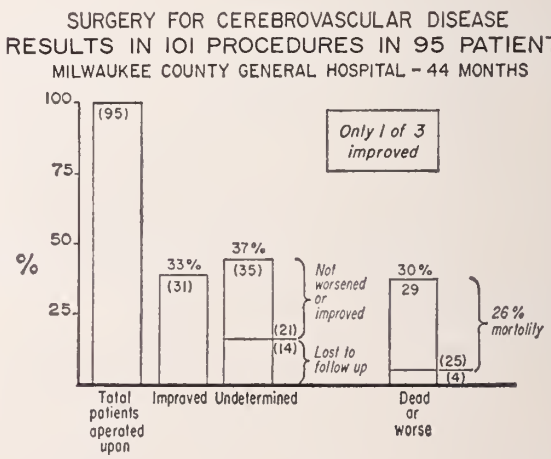

Figure 3—A collected series; selection of patients and operative routines varied from surgeon to surgeon. The undetermined group may have benefited by prophylaxis.

animal laboratory. There we learned that the dog was not a good animal model for cerebral blood flow studies because most of its carotid flow is to the extra cranial muscles.[6]

Again flow measurements were made at surgery,† this time with arterial PCO_2 controls.

†Mr. Kenneth Kaiser, a biomedical engineer, assisted in the technical work in this investigation and helped with many of the calculations.

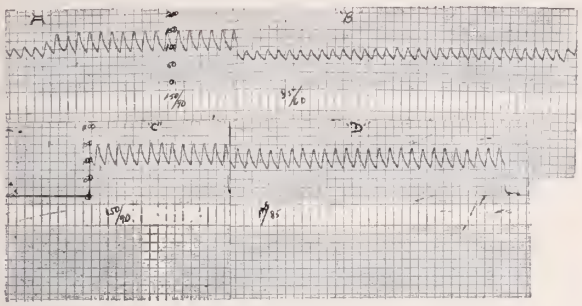

Figure 4—Simultaneous pressure curves, "A", from the common carotid; "B", the internal carotid showing a systolic gradient of 65 ml of mercury before endarterectomy; "C" and "D", essentially no gradient after endarterectomy.

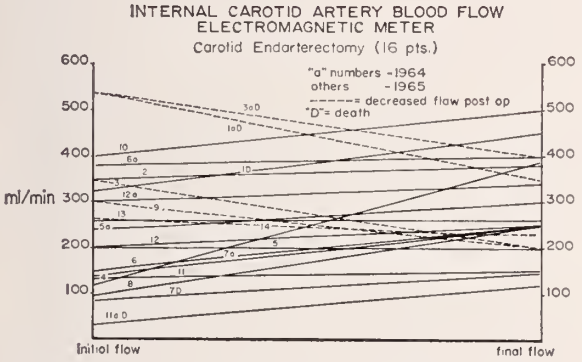

Figure 5—Shows a poor correlation for improved internal carotid artery blood flow after endarterectomy.

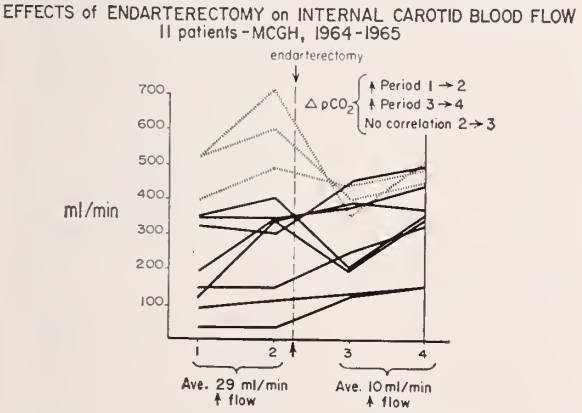

Figure 6—An arterial system capable of a good response to an increase in blood PCO_2 did not always show improved flow after endarterectomy.

Twenty-one patients were studied during 1964 and 1965. The symptoms and degree of stenoses were roughly equivalent in all, but the blood flow measurements (Figs 5, 6, and 7) showed a discouraging scatter forbidding conclusions.

Data abandoned to repose in the "negative results file" for years does not improve with age but reexamination may lead to new insights. The occasion for reviewing these studies came with the realization that the next group of patients reported below showed striking differences from the previous three groups.

From 1966 through 1972 carotid endarterectomy was generally offered to patients on my service only if they met the following criteria.

1. Lateralizing signs—documented.
2. Now neurologically intact or markedly improved.
3. Positive physical findings to include arch studies if absent pulses.
4. Lesions demonstrable on x-ray studies that correlated with clinical symptoms.
5. Neurologic consultation, brain scan, electroencephalographic studies.

The 20 patients in the series were numbered consecutively. Multiple procedures on the same patient are indicated by an alpha suffix. They were then listed in Table 1 by category. There were 9 males and 11 females. The ages ranged from 50 to 80 years. Eight patients were over age 70. There were no deaths. The present status of the patients was elicited from the referring physicians in August 1973. Those patients dead or lost to follow-up are noted.

Eight patients had bilateral procedures, one patient (1b) months later because of new symptoms and the rest as planned procedures with short intervals between operations. Two patients had reoperations on the same artery, one at 18 hours (13b) and one, months later (2b). There were 32 proce-

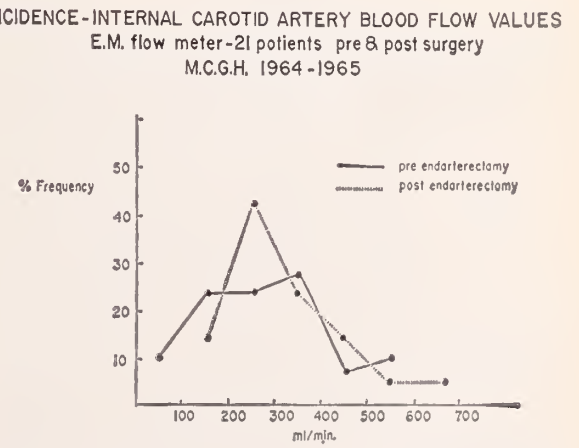

Figure 7—If endarterectomy significantly improved blood flow, the dotted line curve should be above the solid line curve.

aures on 30 arteries with a postoperative neurologic impairment in only one (13b).

Eight of the 20 patients (40%) had complete occlusion of an internal carotid artery, certainly a definitive impairment of cerebral blood flow. In two (17 and 18) such occlusions had no noticeable effect while in the remainder all but one had transient symptoms and generally no residual neurologic deficit. Patient 13b had a complete occlusion (thrombosis in the internal carotid artery) as a postoperative complication. She recovered from the initial operation with a neurologic status equal to her preoperative condition only to deteriorate in the next few hours. Reoperation restored blood flow but did

TABLE 1 — *Classification of 20 patients having carotid endarterectomy*

Group	Patient No.	Symptoms	Complete occlusion	Stenosis	Ulcerated plaques	Endar-terectomy	Result	Comment
	1a	R. paresis-transient	L	O	+	L	+	Mural thrombus, flow restored
	b	Syncope	O	O	+	R	+	o.k. 7 years-anticoagulants for vertebral basilar disease
Group 1	2a	Amourosis Fugax R., numbness L. hand syncope	O	O	+	R	+	See 2b below
Ulceration	4	Mild residual L. paresis, syncope	O O	O L	+ ?	R O	+ O	1 year transient aphasia, refused surgery, now o.k. — 6 years
without	6	Amaurosis Fugax, R. syncope	O	O	+	R	+	o.k. 5+ years-anticoagulants for "cardiac condition"
stenosis	19	R. paresis, clearing	O	O	+	L	?	Slow improvement-o.k. 2 years
	20a	Episodic, L. paresis-syncope	O	O	+	R	+	o.k. 18 months
	b	None	O	O	+	L	?	
	3	Episodic L. paresis	R	L	+	L	+	Died—myocardial infarction—5 years
Group 2	5	Transient R. paresis syncope	L	R	+	R	+	3 hour paresis L. hand, post operatively, o.k. 3 years
	7a	Episodic R. paresis	O	L	+	L	+	
Ulceration	b	None	O	R	?	R*	−	postoperative death elsewhere 2 weeks
and	9a	Numbness and tingling R. hand	O	L	+	L	+	o.k.—5 years
stenosis	11	Episodic L. paresis, confusion	O	R	+	R	+	Web, o.k. 2 years—lost
	12a	R. paresis, cleared	O	L	+	L	+	Web, o.k. 4 years
	13a	Episodic R. paresis clearing	O	L	+	L	±	Improved, then worse—cf 13b
	14b	Amaurosis Fugax R.	L	R	+	R	+	Web, cf 14a—Died—6 months myocardial infarction
	16a	Syncope	O	L	+	L	+	o.k.—4 years
	b	None	O	R	+	R	?	Web
	17	Amaurosis Fugax R.	R	R	+	R	+	Flow restored, o.k. 18 months —lost
Group 3	2b	Dizziness	O	R	O	R	−	Reoperation for kinked artery, cf 2c
	8	L. paresis, recovered, dizziness	O	R	O	R	+	Kinked artery patch, o.k. 5 years
Stenosis	9b	None	O	R	O	R	O	Kinked artery patch
without	10	Progressive dementia	O	L	O	L	O	o.k. 18 months—lost
	12b	None	O	R	O	R	O	Kinked artery patch
ulcerations	14a	Transient-R. paresis	L	L	O	L	O	Flow not restored, cf 14b
	15	?L. paresis, recovered	O	L	O	L	O	Auto. trauma, malingering?
	18	None	L	R	O	R	O	O.k. 1 year—lost
Group 4 No Stenosis no ulceration	2c	Dizziness	O	O	O	L	O	Vertebral basilar disease? Died 3 years dementia—no stroke
Group 5 Postoperative problems	13b	Progressive R. hemi-paresis	L	?	O	L	±	Thrombosis postoperatively, reoperated, patch, slow recovery, o.k. 4½ years

not improve her neurologic defiict immediately. Recovery to her initial preoperative status took place gradually over a period of months. Embolization to small vessels in the brain proper seems as likely a cause for her postoperative difficulty as does a temporary decrease in cerebral blood flow.

Patients 11, 12a, 14b, and 16b had thin webs of intimal tissue that formed their stenoses. Although etiologically unexplained, conjecturally, webs could represent recanalized complete thromboses. Symptoms were transient in three and not elicited in one.

In the 16 patients with ulcerated atherosclerotic plaques, only 3 of 20 arteries (15%) were found to be associated with *no symptoms,* 20b with no stenosis and 7b and 16b with stenosis. All 3 were operated upon a short interval following the initial surgery on the contralateral artery.

In contrast of the 4 patients without ulcerated atherosclerotic plaques[8,10,15,18] all had significant stenoses and therefore presumably decreased blood flow. Only two had symptoms and only one[8] had lateralizing signs. This was the only operative procedure in 8 arteries with stenosis and no ulcerations that resulted in improved cerebral function for the patient (Table 1). This was an artery kinked by fixation due to an abnormal neuroplexus and presumably complete interruption of cerebral blood flow could occur with certain positions of the patient's head.

Improvement after endarterectomy in 1 of 18 (12.5%) arteries with stenosis alone or 1 of 9 without ulcerations (11%) cannot compare to the 100% improvement or freedom from recurring symptoms following endarterectomy in 17 arteries with ulcerated plaques associated with symptoms.

Julian reported a 7% incidence of ulcerative lesions of the carotid artery bifurcation and cautioned against dislodging thrombi during surgical manipulations.[7] The phenomenon of atheromatous embolism was discussed by Edwards and some cases of embolization to the brain were noted.[8] Wylie noted specifically the association of atheromatous embolization and amaurosis fugax[9] but apparently others like ourselves have ignored the true significance of intimal ulcerations in the arteries of patients with cerebrovascular insufficiency. It is of interest to review the photograph of the operative specimen shown in Eastcott's 1954 paper.[1] I believe intimal ulcerations are definitely present.

Atheromatous disease in the carotid system undoubtedly can contribute to diminished cerebral perfusion and produce dysfunction. Our data and that of others[10] suggests that it is difficult to establish reproducable criteria to help select patients for surgery on the basis of decreased cerebral blood flow. On the other hand, transient ischemic attacks are shown to be associated with a high incidence of atheromatous ulceration at the carotid bifurcation and the presumption is that such attacks represent the results of embolization, atheromatous or thrombotic. For this group of patients, carotid endarterectomy is safe and the long-term results are excellent.

JOSEPH M. KING *Festschrift*

IN TWO PARTS: November 1973/Part I
December 1973/Part II

Because of the tremendous response to the call for scientific papers and tributes and because of the economical necessity to limit the number of pages per issue, the Editorial Board has found it necessary to present the Joseph M. King Festschrift in two issues: November and December 1973. The Board further acknowledges its regrets that not all of the material submitted could be included. The Editorial Board wishes to commend with deep appreciation the assistance of Dr. Leonard Worman in coordinating these issues.

Summary

A review of the results of carotid endarterectomy in several groups of patients is presented. An initially high morbidity and mortality rate was greatly improved by more careful patient selection. Measurements of cerebral blood flow by a variety of techniques showed a scatter of results giving little evidence of improved blood flow following endarterectomy. The clinical results correlated poorly with measured carotid blood flow levels.

In the last group of 20 patients there was a high incidence of ulcerated atherosclerotic plaques at the carotid bifurcation. Endarterectomy in this group was associated with no mortality, minimal morbidity and apparently, effectively prevented further transient ischemic attacks. Embolization is thought to be more significant than decreased carotid blood flow in the etiology of transient cerebral ischemia.

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Festschrift

WISCONSIN MEDICAL JOURNAL
November 1973/Part 1

ALBERT G. MARTIN, MD, WILLIAM P. WENDT, MD, DAVID J. LaFOND, MD and CORNELIUS J. RATER, MD, Milwaukee, Wisconsin

Cystadenoma of the Liver; a Rare Tumor

Description of a Case; Review of the Literature

THIS PAPER IS SUBMITTED for the Joseph M. King Festschrift in the hope that the tumor described and the historical review, one of the aspects of our profession for which Doctor King is well known, will be of interest to him.

Case Report

A 30-year-old married white woman was admitted to Lutheran Hospital of Milwaukee in August 1971 with complaints of abdominal enlargement for six months and pain in the upper abdomen for six weeks. In the month prior to admission she noticed that bending forward in the attempt of making beds had become almost impossible because of abdominal pressure and pain. Her general health was excellent. She had two small children.

Abdominal examination showed a protuberant abdomen. The abdominal wall was tight but without spasm. Tenderness was elicited in the upper abdomen. A mass continuous with the liver extended inferiorly to the pelvis, well beyond the midline toward the left side, and filled the right side of the abdomen. The mass was firm, showed no fluctuation, and it was dull to percussion.

Laboratory examinations showed no abnormality: no anemia; no derangement of hepatic function, serum protein levels or electrolyte levels; no evidence of infection.

Barium studies showed displacement of the stomach into the upper left abdomen, displacement of the duodenum to the left of the spine, and crowding of the intestine into the pelvis (Fig 1). The kidneys were not remarkable.

The most helpful study was an aortogram. Unfortunately the large tumor mass impaired the photographic quality of the study and for that reason it is not reproduced here. The study showed displacement of the aorta and pancreas to the left of the vertebral column. The hepatic arteries were elevated and spread, much like the ribs of an opened umbrella. There were no visible large arteries present in the tumor or leading to it. A late phase of the aortogram showed a faint

Figure 1—A barium study shows the general outline of the hepatic mass. The stomach is displaced to the left and upward. The duodenum is displaced to the left of the spine. The intestines are crowded into the lower abdomen and pelvis.

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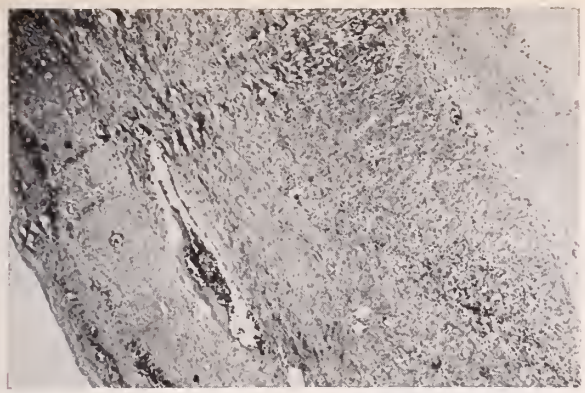

Figure 2—The capsule of the tumor. The dense fibrous connective tissue wall is at the left. The lining of one of the large cystic areas is at the right. It has lost its epithelial lining.

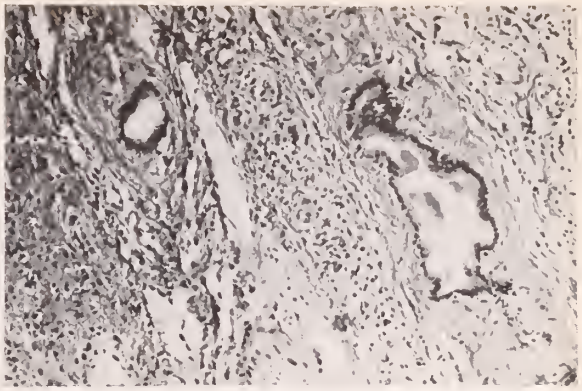

Figure 3—A section from one of the fleshy portions of the tumor. Liver cells, a fibrous stroma, and two cystic bile ducts are present. The ducts are lined with columnar, mucus-secreting cells.

hepatogram in which the liver resembled a polar ice cap perched upon the top of a much larger globular mass. Except for being distorted, the liver showed no defects.

We concluded this woman had a tumor of the liver, possibly a cyst, probably not malignant, but none of us knew its precise nature until later.

At operation a transverse upper abdominal incision, later extended into the right chest, was used. When first opened, the abdomen seemed to be filled with liver, from the dome of the diaphragm down to the pelvis and from one side to the other. Most of the mass looked and felt very like liver but there were large blue green cystic areas in it. The other viscera were healthy but displaced. The gallbladder was in the right midaxillary line.

Guided by the hepatogram, an attempt was made to elevate the visceral peritoneum from the mass a few inches below the zone where normal liver would be expected. The peritoneum was mobilized upward and soon normal liver was encountered. The tumor had a stout capsule, the demarcation between liver and tumor was clear, and separation of the tumor from the liver by blunt dissection was not difficult. In the course of the dissection, many resistant strands of tissue were encountered, ligated and divided. They had the characteristics of arteries, veins, and bile ducts. Some were large.

The tumor actually arose from the anatomical junction of the right and left liver lobes. At the point of its emergence from the hepatic parenchyma, the edge of the tumor and the common hepatic duct were separated by 4 or 5 cm. It is probable that the hepatic ducts were fairly close to the tumor capsule in the areas where the tumor was intrahepatic.

The tumor was removed intact. It weighed 11,250 gm. The large, deep defect in the liver was covered by the peritoneal flaps which had been raised early in the operation. Penrose drains were placed within these flaps.

Pathology Report

The specimen was a cystic mass measuring 30 x 25 x 15 cm. It had a fibrous surface, was bluish-red in color. The fluid within it was mucoid, cloudy, and greenish gray. The tumor contained numerous large cystic locules of approximately equal size. They had a smooth, very slippery internal lining. In some areas the lining was coated with a deep green, tenacious substance.

Sections from the cyst wall showed that it was composed of dense fibrous connective tissue in which there were moderate numbers of blood vessels. Parts of the cyst no longer had an epithelial lining and here one could see loosely proliferating fibrous connective tissue (Fig 2). In portions of the wall there were islands of somewhat distorted liver cells and occasionally a normal bile duct (Fig 3). The ducts were lined by an epithelium composed of moderately tall epithelial cells with rounded, deep staining but entirely normal appearing nuclei. Where the lining of the cyst was viable, it was composed of low columnar epithelial cells resembling the bile duct cells but somewhat less tall. These cells were sufficiently flattened that it was difficult to appreciate any mucous content but histochemical studies for mucus revealed a very small amount of PAS positive material in some of these cells.

Nowhere was there any evidence of malignant change. The diagnosis was bile duct cystadenoma of the liver.

The lesion, then, was a true neoplasm, but not malignant. It was characterized by the criteria of hepatic cystadenomas as described by Edmondson[1] who states, "The term cystadenoma should be confined to the multilocular cystic tumors which are lined with columnar epithelium and have a dense cellular stroma."

The patient made a prompt, uncomplicated recovery. A very small amount of serosanguinous fluid followed the drains to the dressing. There was no bile drainage.

Two years after operation, the patient remains well. The transverse scar is now at the level of the lower sternum. The abdominal incision had been placed midway between xiphoid and umbilicus.

Discussion and Historical Review

The tumor removed had the following characteristics: stout capsule; multilocular, the locules varying from a few millimeters to a liter or more in size; mucinous fluid within the cysts; fleshy, almost parenchymatous solid areas. It arose from the under surface of the liver at the junction of the anatomical right and left lobes. The liver contained no other cysts or tumors.

Cystadenoma of the liver should be distinguished from polycystic disease of the liver and from unilocular cysts containing clear fluid. Such a distinction is

required for purposes of precision and for proper treatment, but is not always easy. A review of the American, British, and portions of the Continental literature revealed over 25 synonyms and frequently reminded the authors of James Ewing's statement[2] made in 1919 in his first edition of *Neoplastic Diseases*: "The recent rapid increase in original contributions from the United States has made it impossible to do full justice to the American literature." Also, in reviewing reported cases of solitary or localized cysts of the liver, it is often difficult to determine which of them are cystadenomas. It is probable that 300 to 400 cases of cystic, nonparasitic hepatic tumors have been reported and it is further probable that less than half can be precisely identified as cystadenomas.

In 1856 and again in 1859, J. S. Bristowe,[3,4] a London pathologist, discussed the association of polycystic disease of the liver and kidneys, and he noted that such an association is uncommon. Whereas

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Truly Great

Dr. Joseph King has been privileged to hold the chair of surgery at Marquette, a richly deserved attainment based on plain hard work and astute knowledge with teaching ability far beyond usual. But Doctor King also has been privileged to sit in a chair and watch the development and changes through one of the greatest eras in the history of medicine. He often referred to his great privilege of having been "on the scene" through years which linked ages of medicine; at one end just beginning to emerge from a dark segment in time when the "art" of medicine outweighed the "science" of medicine to a considerable extent and terminating his career when science at last became solidly dominant with lacings of the art just enough to accomplish necessary compassion.

Throughout it all, Doctor King's deep and personal compassion for his patients was a hallmark of his work and his teaching. I remember his tender concern imparted to a nervous, perhaps frightened freshman medical student suffering from pre-exam anxiety—the thought never left me for, as he approached the student, his natural manner seemed curt and even gruff but after serious examination and quiet discussion there emerged a feeling of confidence that all of the great field of medicine lay ahead, and that only reasonable industry, not genius, was needed to learn and apply all that would follow. A kind, fatherly touch was all that was needed at that moment, but there was no cursory dismissal—a trait not to be unexpected from a man who, within the next hour, might be doing a craniotomy.

CRANIOTOMY? As I indicated, this man's career bridged a time when a competent general surgeon was expected to do this sort of thing and with instruments probably now museum pieces. Yet no one saw the need of development of sophisticated neurosurgeons than Joseph King—more than one developing surgeon was gently steered into specialty areas of surgery by this astute teacher—who was able to see the trends and needs for ever more complex research, training, and ability.

I saw him give the last of the Kimpton-Brown transfusions at Milwaukee County Hospital. Could that possibly be in the era just before the use of blood banks? Yes, they had to resurrect an old K-B tube, prepare it and the patient, and carry out the transfer of blood at the insistence of one of the consulting surgeons at MCH. I talked to Doctor King after it was over and he admitted that the method was old but the patient could do nothing but benefit from the transfusion and the older consulting surgeon's methods were extremely deeply respected. On several later occasions I heard him refer to the "old" in its development of the "new," and if transfusion is an example of over-riding an era, so it is. He never ceased marveling at the laboratory advances that made blood transfusion as facile as it is today when, as he began his career, the laborious K-B with the uncertainties of blood matching was the best that could be done.

There are any number of amazing strides that were spanned in his time in medicine: the battle of the pneumonias, the whole antibiotic parade, the great reduction of osteomyelitis, empyema of the chest, treatment of peptic ulcer through surgery, the terror of tuberculosis in any form, but mostly the practical obliteration of tuberculous osteomyelitis and meningitis, the horrors of eclampsia, the extended range of vascular surgery, the whole area of blood coagulation, noncoagulation, thrombosis, and embolism. You see, while this is only a partial list of the passing scene witnessed through Joe King's career, they are mentioned because he was part of that scene.

You mean to say he applied surgery to all these divergent problems? Well, yes, and possibly

polycystic disease of the kidneys seldom is accompanied by polycystic disease of the liver, he suggested that when polycystic disease of the liver occurs, it is frequently associated with polycystic disease of the kidneys.

In the livers he studied, the cysts were thickly disseminated throughout the entire organ. They varied in size from mere points to about an inch in diameter. The cyst walls were lined by "a distinct layer of small, flat cells . . . in no respect different from serous membrane." The fluid was usually serous, and occasionally reddish-brown inspissated material.

In 1894, Dmochowski and Janowski[5] described a 48-year-old woman who had disseminated cystic disease of the liver associated with polycystic kidneys.

Moschcowitz,[6] in 1906, stated that multiple hepatic cysts are often associated with cystic kidneys and occasionally with cysts of the lungs or pancreas. His evidence was the study of fetuses who had other

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no, but it seems to me now that many of the problems required almost immediate treatment so that residents and interns at old County had to get hold of the voluntary staff—a task not always accomplished. But there was always an ace-in-the-hole: good, dependable, always available and never complaining Joe King. Dinner-time, midnight, early dawn—never a moment that he was not ready and willing to be called. One would think we would wear him out, but he was so respected and decent that all of us instinctively tried to avoid this last appeal for help.

I called him one time when the operating surgeon could not be found, and his response, without complaint or question, was so prompt it made a lasting impression on me. In this particular case, a terminal malignancy, bleeding to death, received her quiet and tender assurance from a very sleepy but utterly sympathetic man whom I hated to rouse just because I could find no one to respond to the problem which was beyond my own judgment and abilities. He did not complain that I had called but took time after to talk over the need for tender sympathy even in the most terminal of cases.

His instructive talks were laced with stories, some of them extremely funny and every one with a true raconteur's finesse. He had a memory like a computer and if I ever heard a story twice or more it didn't vary a hair—perhaps the greatest test of truth—his title: honest Joe King.

The story of the anesthetic administered via the "new" machine, gas bag and all, announcing to the surgeon that the patient was ready only to find out, when the patient yelled, that the bag had a big hole in it—not funny, but when properly embellished with cast of characters and circumstances it became a lesson, an anecdote, a quiet chuckle, and an impressive surprise-ending at once.

And the story of the Turk having a hepatic mass. Every clinician had a note on that chart, and speculative diagnoses ran the gamut from bilharziasis to primary hepatoma, but no surgery was permitted and the poor Mohammedan died. Permit for autopsy was emphatically denied and the whole problem and some bets were destined to go unsettled. Judson the Undertaker picked up the remains to prepare for shipment to Michigan or some other place. Judson—a character in his own right—took the body to the old, green, storefront mortuary and later complained that the man had "such a big thing stuck in his belly" he had to cut him open and cut it off to get him in the coffin. Joe King undoubtedly trembled as he asked what it looked like and what was done with it; but alas, Judson could not remember and thought he had burned it in the stove. A great loss to science but, by way of illustration, no loss to make a point in teaching students the value of obtaining a post permit.

Then again his story of the shooting of Teddy Roosevelt here in Milwaukee, best garnished with Joe King's dramatic illustration of the President's appearance at the Auditorium—Joe could really look like Theodore Roosevelt as he showed where the bullet hit and the blood on his shirt to a big crowd marveling at his courage. The story had more than a good imitation to it; it included the famous early-day x-ray study done by Janssen at County Emergency. Then following Roosevelt's courageous appearance, a special train trip to Chicago ostensibly to a waiting delegation of prominent surgeons at the depot. But fate and Dr. John B. Murphy modified matters by having the train side-tracked at Evanston, transferring Roosevelt to an ambulance and then to Mercy Hospital where the bullet was removed. As told by Joe King you had the distinct impression you were there! He politely left to your imagination the expressions on the faces of the waiting medical delegation at the station.

Oh, I know how many of us have been touched by the energy, kindness, honesty, and humor of Dr. Joseph King; it would take a book to fill in every detail but shortly, this I know, there are literally hundreds who will never forget him, as I do now—truly great—truly great.

—L. J. Van Hecke, MD, Milwaukee

congenital malformations. He cited cases where a cyst in the liver of the fetus was so large that it obstructed delivery. He concluded, "There is no valid reason for classifying these cysts among tumors."

Longmire,[7,8] Lin,[9] and other authors have come to similar conclusions.

When polycystic disease of the liver becomes a clinical problem, the common presenting sign is hepatic enlargement. Bevan[10] opened, evacuated, and closed numerous cysts and removed one for examination. Lin[9] treated three cases successfully by unroofing the surface cysts and fenestrating deeper ones.

On occasions, single large cysts have been observed in patients who have polycystic disease of the liver. Belcher and Hull[11] reported three such cases. In each instance the cyst was aspirated and then the dome of the cyst was excised. The fluid contents were 600, 1,450, and 2,000 ml respectively. All patients recovered and remained well without recurrence, two for 18 and 15 years. von Meyerburg,[12] Claggett and Hawkins,[13] and Johnston[14] also report patients who had an unusually large cyst along with polycystic disease of the liver.

Solitary unilocular hepatic cysts represent a large proportion of cystic hepatic tumors[15] and are to be differentiated from cystadenomas because the treatment of the two conditions is so different: solitary cysts may be drained; cystadenomas are best removed.

Both lesions must be differentiated from polycystic disease, parasitic cysts, congenital cystic lesions of the biliary tree,[7] dermoid cysts, liver abscess, hematomas and their sequellae, large hemangiomas and degenerated metastatic deposits.

Solitary cysts, as the name implies, are usually single. Rarely, two or three may be found. Edmondson[16] calls them "multiple simple cysts."

Michel,[17] in 1856, may have been the first to report such a cyst.

The ingenuity of nineteenth century surgeons is illustrated by the experience of Chroback,[18] a Viennese surgeon who in 1897 encountered a large cyst of the right lobe of the liver in a "worn out" middle aged woman. The great size of the cyst deterred attempts at excision. Instead, the liver and cyst were mobilized and exteriorized. Nine days later the cyst was opened and over a half liter of fluid was released. Recovery followed.

These cysts may occur in any part of the liver, although most have been found in the right lobe. Jaundice, due to pressure of the cyst on the bile ducts, has been reported.[19,20] The walls of these cysts are relatively thin. The fluid contents may be clear or colored but, unlike cystadenomas, mucus is not present in the fluid. Simple drainage, unroofing, partial excision, marsupialization, internal drainage and excision have all been reported as successful methods of treatment.[7,15,21,22] The non-neoplastic nature of these lesions makes possible the success of measures short of excision.

Fostered by the skill and ingenuity of nineteenth century surgeons, methods of hepatic resection and successful treatment of cystic hepatic tumors developed simultaneously. Differentiation between the neoplastic cystadenomas and the simple though large hepatic cysts developed more slowly.

Jones[23] reported that Kaltenbach of Marburg, in 1885, encountered a large multilocular hepatic tumor. Three hundred and twenty liters of viscid, greenish-brown fluid were obtained by several punctures. After tightening an elastic ligature around the base, the tumor and "a hand's breadth of liver lobe" was removed. Hemorrhage was controlled by suture. The patient recovered, remained well, and showed no evidence of recurrence five years later. He reported further that Koenig of Goettingen extirpated a cystadenoma of the right lobe of the liver in 1886.

Langenbuch[24] is generally credited with having performed the first successful hepatic resection in 1888. His patient, a woman 30 years old, had a deformed left lobe of the liver, the result of having worn tight corsets. The deformed portion of the lobe was removed. No tumor was present. Severe postoperative hemorrhage from the liver required a second operation that evening. The liver was resutured. Recovery followed.

In 1892, W. W. Keen,[25] the newly appointed Professor of Surgery at Jefferson Medical College, operated upon a 31-year-old woman who was thought to have a floating kidney. John Chalmers da Costa was his assistant. Doctor Keen found a tumor of the right lobe of the liver and he removed the tumor intact, using "finger nail dissection" and cautery. The liver defect was sutured. A glass drain produced three ounces of bloody serum in the first 24 hours, very little thereafter, no bile, and was removed in 48 hours.

Postoperatively the patient was given ice, champagne, and quarter grain doses of cocaine. She recovered and remained well. The tumor was a cystadenoma. This was the first successful removal of a liver tumor in our country. This experience prompted Keen to perform hepatic resections for a variety of other conditions. He showed that hepatic resections, greatly feared at that time, could be done safely.[26]

Eight years later, F. C. Shattuck[27] described an experience with a similar tumor but a different result. The patient was a young woman who had a smooth, dark red tumor of the right lobe of the liver which filled the right half of the abdomen. The tumor was partly solid, partly cystic. The cystic portion was drained of about a gallon of colorless fluid and the cyst wall was marsupialized. Profuse drainage from the cavity became bile stained, persisted, and finally leveled out at about one and one half pints per

day. An operation to close the sinus was not successful. The patient died two days later.

The contrasting experiences of Keen and Shattuck are repeated over and over again in the American, British, and Continental literature: removal of a cystadenoma is usually followed by prompt recovery, as reported by Corrin,[28] Gerber,[29] Monnin,[30] Morgenstern,[31] and von Skaliczki;[32] drainage is usually followed by recurrence or by a high output biliary fistula which persists and often demands a second operation, as reported by Evans,[33] Koban,[34] Leppmann,[35] Snedecor,[36] and Warren and Polk.[37] These secondary operations carry a high mortality.

Beginning with Keen, a galaxy of Philadelphia surgeons contributed to the understanding of cystic tumors of the liver and their treatment.

In 1922, John F. X. Jones[23] reported the successful removal of a "retention cyst" from the liver. It had the microscopic characteristics of a cystadenoma. He also reviewed the literature and summarized reports of 61 cases of nonparasitic hepatic cysts.

In 1934 Eldridge Eliason[38] successfully removed a hepatic cystadenoma from a 3-year-old female infant. He drained the cystic portion and then enucleated the partially collapsed tumor. He also studied the incidence of solitary nonparasitic hepatic cysts at the Philadelphia General Hospital and found 28 cases in 20,000 autopsies.[39] Edmondson[1] found 309 hepatic tumors in the first 50,000 autopsies at the Los Angeles County Hospital. Most of the tumors were hemangiomas and primary carcinomas. Four were adenomas of bile duct cell origin.

In 1955, D. C. Geist[40] reported on two patients for whom he excised hepatic cysts which proved to be cystadenomas. His review of the literature included 193 cases. He is one of the few surgeons who has had the opportunity of operating upon more than one cystic tumor of the liver.

A basic handicap in the understanding, classification, diagnosis, and treatment of large hepatic cystic tumors has been the limited experience of individuals and groups with these lesions. Few surgeons have seen one such lesion and fewer still have seen two.

Congenial Companion

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It pleases me to be asked to write a few words about this remarkable man.

Of course, I knew something of Joe King through his colleagues and some of the many surgeons who owe their training to him. I knew that, as Director of Surgery at the Milwaukee County Hospital and as Professor of Surgery at the Marquette Medical School, he was dedicated to excellence in surgical care and to the development of good surgeons by setting an example and by teaching the best surgical principles. I knew that because of his intolerance of laziness and slipshod work, his plain speaking and his insistence upon proper principles of ethics, he was often considered gruff and austere.

However, my real knowledge of Joe has come about by personal contact with him in the activities of the Wisconsin Surgical Society and especially in the travels of the Wisconsin Surgical Club. I soon found this "austere" man to be a most congenial travel companion with an immense sense of humor. His inimitable story-telling has enlivened and brightened many a trip, especially when the story necessitated an Irish brogue. I believe none of us of the Wisconsin Surgical Club can ever forget his famous "White Horse" story which we, Conde Conroy excepted, have demanded again and again.

Joe's wealth of experience and remarkable memory have made him an unusually interesting conversationalist with many anecdotes about people and strange happenings. His interest in medical history has produced exceptional contributions—Historical Backgrounds of Wisconsin Surgery and Medicine in Milwaukee in the Nineteenth Century.

Doctor King has the kind of mind which enables him to quickly realize the important elements in any presentation or discussion. This ability plus his critical sense has made his comments pithy and to the point.

Even a short acquaintance with Joe suffices to make one aware of qualities which have made him much admired and loved: his absolute honesty, his lack of subterfuge, his devotion to his Irene and their children, and his loyalty to those who merit his friendship.

I salute Joseph Martin King, able surgeon, dedicated teacher; man of integrity, devoted to his family, loyal to his friends; a most congenial companion who has made my life more pleasurable and has helped much to maintain my faith in man.

—WARNER S. BUMP, MD, Rhinelander

In the late nineteenth century and the early twentieth century, differentiation between parasitic and nonparasitic cysts seems to have been paramount. Later on, good results followed drainage or partial excision of some cysts and biliary fistulas and recurrence followed similar treatment of other cysts. This difference in results suggests a fundamental difference in the nature of the cyst treated. The term cystadenoma has been most frequently used to describe the cystic, fleshy, usually multilocular hepatic neoplasms which should be differentiated from large simple cysts and from large cysts of polycystic disease.

The term "cystic mesenchymal hamartoma"[14] occasionally has been used to describe the neoplasm more frequently described as cystadenoma. When a surgeon recognizes the difference between simple hepatic cysts and the neoplastic cystadenomas, he can drain the former and excise the latter with confidence.

These tumors seldom rupture spontaneously. When they do, the symptoms are those of a ruptured viscus.[31] Death from peritonitis has been reported following rupture.[41]

A recent development has been the occasional observation of malignant degeneration in cystadenomas,[42,43] as well as in simple cysts of the liver and in cysts of polycystic disease of the liver.[44]

Preoperative studies helpful in the diagnosis of hepatic tumors are scintillation scanning[45] and aortography. The late phase of the aortogram also may show a hepatogram.

At the time of operation the nature of the cystic tumor is often clear on gross examination. If it is not, examination of the fluid contents should show clear fluid in simple cysts and mucoid fluid in cystadenomas. Biopsy may be helpful. The fact that malignant degeneration has occasionally been observed in cysts of all kinds influences treatment; for such lesions, when present, impose the additional requirement of removal of the tumor intact and with a margin of healthy tissue. When these large cystic tumors are removed, the principal technical hazards are blood loss and injury to the hepatic ducts.

Conclusion

A case of cystadenoma of the liver has been described. This rare tumor is a true neoplasm. While instances of malignant degeneration have been described, the tumor is usually not malignant. It occurs in females more frequently than in males. Most patients are in the third or fourth decades of life. While it may develop in any portion of the liver, it most often presents on the under surface at the anatomical junction of the right and left lobes.

The prominent presenting symptoms and signs are those of pressure and distention from a large, easily demonstrated abdominal mass which is continuous with the liver. In addition to the usual studies, aortography is a helpful diagnostic measure.

Hepatic cystadenomas are fleshy and they contain numerous cystic areas which are filled with mucoid bile-stained fluid. Microscopic examination shows distorted liver cells in dense fibrous connective tissue. Ductal structures resembling normal bile ducts are present and are lined by columnar mucus-secreting epithelial cells.

At the time of operation, cystadenomas of the liver are to be distinguished from the other tumors which may be found in the liver and especially from simple cysts, usually unilocular, and from the large cysts which occasionally occur in polycystic disease of the liver. The cysts mentioned are filled with clear fluid which does not contain mucus. Their walls are thin and lined by flat cells, resembling a serous membrane. They may be treated by unroofing, simple drainage, marsupialization, or internal drainage. In doubtful situations aspiration of the cyst contents or biopsy may be helpful.

Removal of cystadenomas is recommended. If they are drained, growth continues, a high output biliary fistula usually develops, and a dangerous secondary operation is required. Removal may be accomplished by hepatic resection or by lobectomy. For tumors at the junction of the lobes, enucleation has been satisfactory. Technical factors to be considered are control of large blood vessels and avoidance of injury to the hepatic ducts.

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JOSEPH M. KING ***Festschrift***

WISCONSIN MEDICAL JOURNAL
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With Dignity and Humility

Dr. Joseph Martin King, skillful surgeon, compassionate physician, unpretentious teacher —the man honored for giving so much of himself to the care of his less fortunate fellowman and to the education of medical students and residents.

He gave uncounted numbers of hours in the operating room administering to the County indigent, with dignity and humility, while teaching and transferring the foundations of Surgical Medicine to young residents. This commitment left few moments for contemplation or for research. Chairmanship of the Department of Surgery, Marquette University School of Medicine, therefore eluded him, but, were it otherwise, this void in his professional life could be reasonably expected because Joe King disdained personal recognition!

I have known Doctor King as a surgical NOW MAN—never more sagacious than in the assessments of acute surgical catastrophies, but often equally perceptive at bedside with nonsurgical ailments.

As Director of the Department of Surgery, Milwaukee County Hospital, for more than three decades, Doctor King helped fashion the ties of County Government with Marquette University School of Medicine. Today's anticipation of a Major Medical Center has roots in the achievements of those days when a few well-meaning men, sans evasive euphemisms, agreed to agree.

Those whose lives in medical education and the practice of Medicine this Master Surgeon has touched shall always remain his admirers. Others shall be grateful for the introduction to him by the "festschrift." All wish Dr. J. M. King and his family the blessings accrued from his devotion to God and his service to man.

—JOSEPH F. KUZMA, MD, Milwaukee
President, Milwaukee Surgical Society

Tributes

Excerpts from a collection of letters

JOSEPH M. KING *Festschrift*

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"I reflect also on my early exposures to you at Marquette and 'County'—Dog Surgery and Internship—Fear and Respect!! More importantly, I reflect on how, as one got to know the 'Old Man' in the course of our residency, we came to know a tender-hearted, compassionate man—one who became a true friend whom we knew we could depend on!!"
—George D. Schmitt, MD, Panorama City, Calif.

"Having known you for over 30 years I have always admired you for your dedication, your straight forward approach, and your shining example as a father. I sincerely hope that when my time comes to retire, people will say the same things about me that they say about you. Then will I feel my life was a useful one . . . from your Puerto Rican admirer."
—Alfred L. Axtmayer, MD, Santurce, Puerto Rico

"I am getting along in years myself, and as I look back on my years of education and training in several schools and hospitals, I recall but four or five men who have had a profound influence on my life. I want you to know that you are one of them. I admired your skills in medicine and surgery and your ability to convey your knowledge to the student. Above all, I have admired your unequivocal convictions regarding morals and ethics. Your influence on me has been profound, and I treasure my association with you."
—T. E. Kilkenny, MD, Eau Claire

"I think one of the best things I carry with me from you is the fact that you taught me to stand on my own two feet and make decisions. There was a certain 'feel' that you had for medicine which I envy to this day. It was beautiful to see you come in and evaluate a patient; say a few words of suggestion, and completely change the course of the patient from chaos to cure. Doctor King, you certainly are an example of a physician who balanced skill, science, and sympathy to make medicine an ART—not a computer science."
—Raymond L. Annis, MD, Joliet, Ill.

"In later years Doctor King became a favorite friend and companion on our many trips across the country with the Wisconsin Surgical Travel Club. Most of all, I admire Joe King as a very fine and great man."
—M. G. Rice, MD, Stevens Point

"It was a momentous occasion some seventeen years ago when I received notification that I had been accepted in the surgical residency program at Milwaukee County General Hospital. With few exceptions, each succeeding day since that time has been one of enjoyment, excitement and satisfaction with the field of surgery. As I have expressed to you in the past, I recognized then and continue to realize the role you played in initiating my career and guiding me throughout my years of training."
—John J. Foley, MD, Menomonee Falls

"Do you remember my prideful message that I had achieved certification—and, incidentally, had added a baby daughter to the family? Your written reply was in part, 'First of all, let me congratulate you on the new daughter. That is much more important than passing the Boards . . .' I could not then appreciate the natural order of things. In a letter of later date you wrote that, as requested, you had recommended me for a teaching post. Then you ticked off a 'few' (four to be exact) guidelines for me to follow. PROMPTNESS was just one of them, but it was underlined! The guidelines have served me well."
—George Bordenave, MD, Geneva, Ill.

"I appreciate most your straight forward honesty for I have never known you to do a devious thing. Truly you are a 'Man for All Seasons.' "
—Thomas J. Pendergast, MD, Wauwatosa

"Your competence and skill, your loyalty to your patients, your honesty and fairness to your associates are qualities which have characterized your career. Your unfailing memory, instant recall of names and faces and humorous stories will long be remembered. We hold you, 'Joe King,' in high esteem."
—H. A. Norum, MD, Fargo, N.D.

Lobular Carcinoma in situ of the Breast

L. D. GRABER, MD, Oshkosh, Wisconsin

JOSEPH M. KING
Festschrift

WISCONSIN MEDICAL JOURNAL
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I am very proud that I may be able to contribute to the honor of Dr. Joseph M. King. Not only do I look back upon Doctor King's surgical teaching as excellent but the older I become the greater respect I have for the advice he gave me. Doctor King often told us, "A great deal more can be learned from a few cases studied well than a great number not so well studied." I hope this to be apropos of this report of a few cases.

AFTER THE VAST AMOUNT of study given carcinoma of the breast, it is difficult to explain the confusion in its treatment. This subject has been statistically studied for years without a convincing conclusion in treatment. The failure arises chiefly from the fact that carcinoma of the breast cannot be considered one disease but several behaving differently. The behavior and the pattern of lobular carcinoma in situ differs from the ductal carcinomas and deserves separate attention. Our experience, although small, is interesting if not instructive. We have attempted to point out that the statement made at the American College of Surgeons meeting in 1971, that "women should insist that the doctor do the least surgery for tumors of the breast," does not hold for lobular carcinoma in situ.

Lobular carcinoma in situ of the breast is not a common lesion nor has it been recognized as an entity for many years. In the larger series it represents about 6% of all carcinomas of the breast. From our experience it has not been that frequent. It was first described by Foote and Stewart[1] in 1941. Because of the low incidence and the recent description of the tumor it is not surprising to find it not recognized by some of our surgeons and surgical pathologists. These lobular tumors had been recognized prior to 1941 as shown by illustrations in older books but were neither categorized nor accepted.

There is no way in which a clinical diagnosis or a diagnosis from the gross specimen of lobular carcinoma in situ can be made. Cancer of this variety, whether infiltrating or in situ, occurs in the same age group as those bearing other mammary cancers. Clinical presentation of patients having in situ lobular carcinoma is different from that of patients having other forms of breast cancer in that it is asymptomatic and is often associated with unrelated breast lesions such as the common fibrocystic disease of the breast. Because of this it is not unusual that the pathologist will report the frozen section negative for malignancy and after reviewing the permanent sections report the diagnosis of lobular carcinoma in situ.

The mammary gland is composed of 12-24 lobules which radiate out from the nipple. Each lobe is supplied by a single lactiferous duct which connects to the nipple. Distally this duct branches into smaller intralobular ducts and finally ends in a lobule. It is from the duct apparatus of these lobules that this carcinoma is thought to arise. This differs from other forms of cancer of the breast which arise from the major ductal system. Carter et al,[2] in the Johns Hopkins laboratory, made a study of cancers of the breast with the electron microscope and found consistent ultra structural intracellular features which were present both in the invasive lobular carcinoma as well as the in situ. These features were sufficiently distinctive to differentiate them from other known cancers of the breast.

Microscopically, in lobular carcinoma in situ, one finds the terminal ducts comprising the lobules dilated and crowded by round loosely cohesive cancer cells. There is no invasion through the basement membrane. The nuclei are rather uniform and symmetrical. As mentioned before, this is most often associated with other diseases of the breast. The foci may be very small compared to the other disease. It is usually multifocal and remaining tumor is found in the breast after excision of the palpable tumor 50% of the time. It is thought to be present in the opposite breast 35% of the time.

In an early series of lobular carcinoma in situ treated only by excision of the tumor 40% developed invasive lobular carcinoma between 2 and 23 years following the excision.

Case Reports

We have treated four patients who had lobular carcinoma in situ. The first case is that of a 35-year-old woman

Reprint requests to: L. D. Graber, MD, 650 Doctors Court, Oshkosh, Wis. 54901.
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who was seen in October 1965. She had a tumor of the left breast located in the upper outer quadrant. An excisional biopsy was diagnosed as fibrocystic disease. In March 1968 she returned with tumors located in both breasts. A review of the 1965 biopsy showed lobular carcinoma in situ. Excisional biopsies again were taken. The left breast showed lobular carcinoma in situ. The right showed fibrocystic disease. We did a bilateral simple mastectomy which may be too radical, as the right breast did not show tumor; the left breast contained residual lobular carcinoma in situ. If we had not removed the right breast, it would have been examined at frequent intervals because of 35% incidence of this disease being bilateral.

The second case was that of a 46-year-old woman with tumors in both breasts. An excisional biopsy

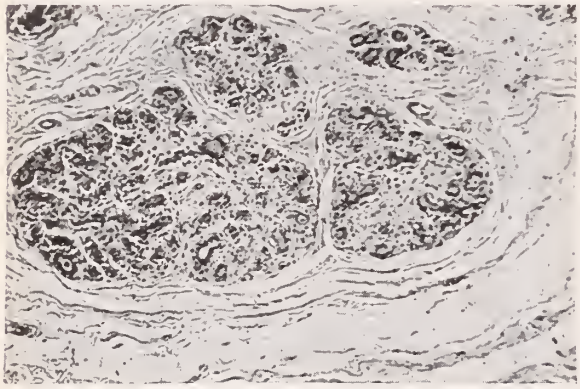

Figure 1—Benign lobule of breast. Note the double layer of cells in the terminal duct.

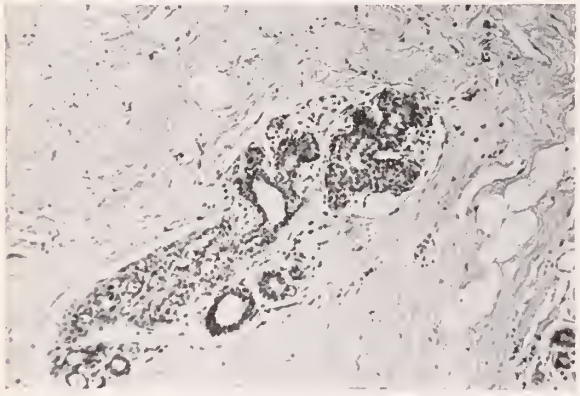

Figure 2—Atypical terminal duct hyperplasia. May be the origin of lobular carcinoma in situ.

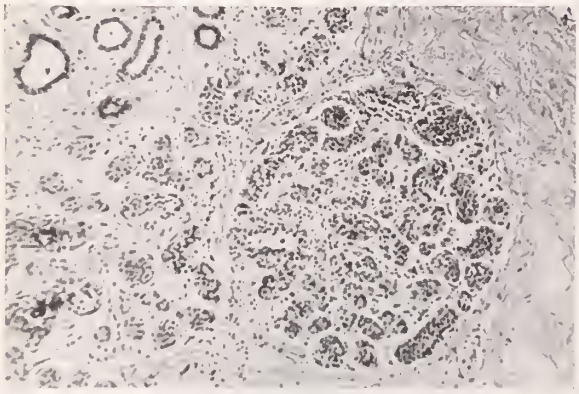

Figure 3—Lobular carcinoma in situ. Lobules filled with loosely cohesive tumor cells with no penetration of the basement membrane. There is uniformity of size of the cells and their membranes and expansion of these cells into the terminal ducts. Note the associated benign breast disease.

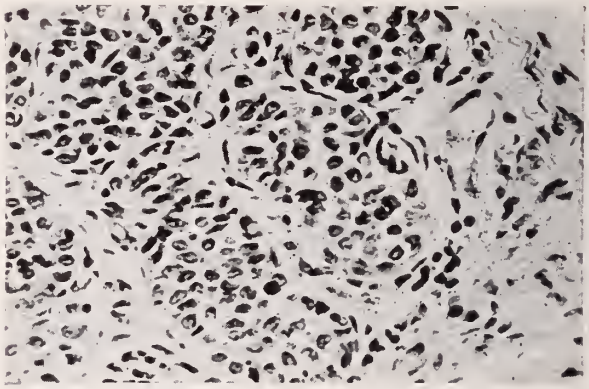

Figure 4—High-power lobular carcinoma in situ.

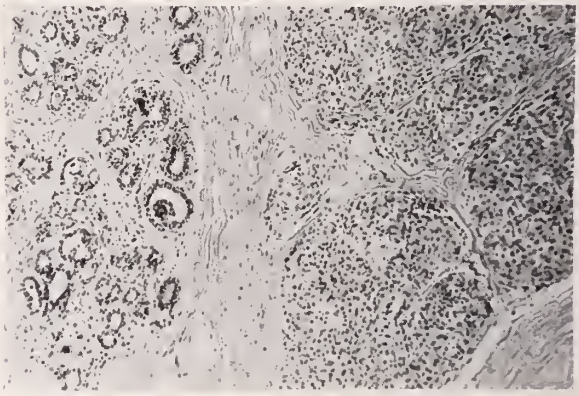

Figure 5—Case 3. Tissue removed from left breast in 1962 and not recognized as lobular carcinoma in situ.

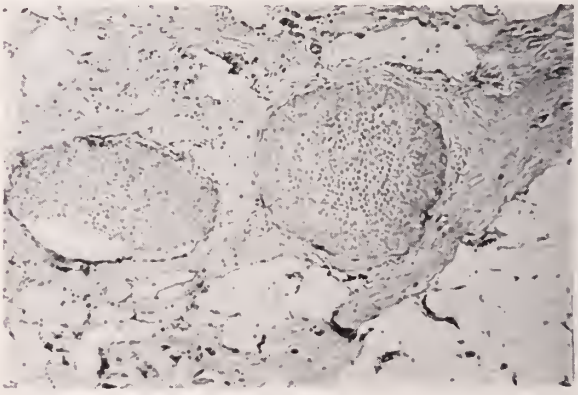

Figure 6—Case 3. November 1970. Same breast, left, invasive lobular carcinoma.

was not conclusive on frozen section but on permanent sections the left breast showed lobular carcinoma in situ and the right showed a typical terminal duct hyperplasia. This is described, without proof, by McDevitt et al[3] as possibly progressing to lobular carcinoma in situ. We were less radical here and did only a left simple mastectomy. The removed breast showed residual multifocal tumor. We are watching the right breast and so far there has been no recurrence.

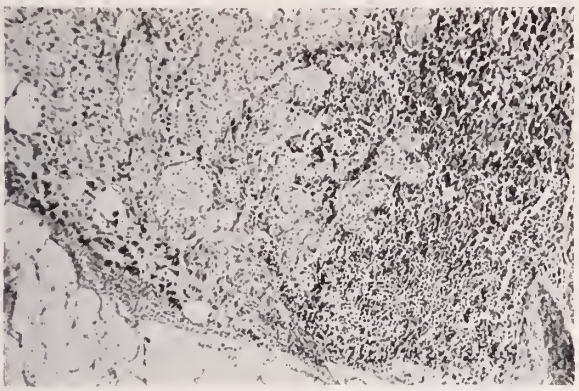

Figure 7—Case 3. November 1970. Associated left axillary lymph node metastasis.

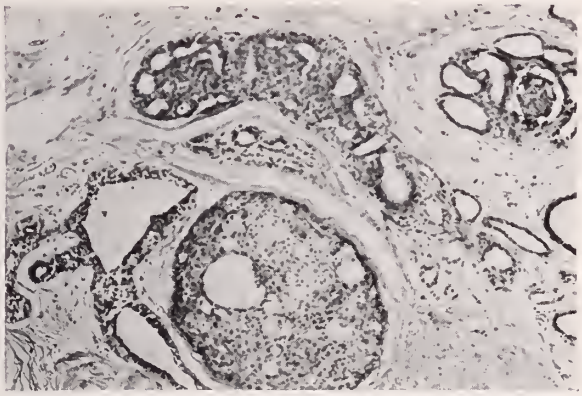

Figure 8—Case 3. August 1973. Right breast lobular carcinoma in situ.

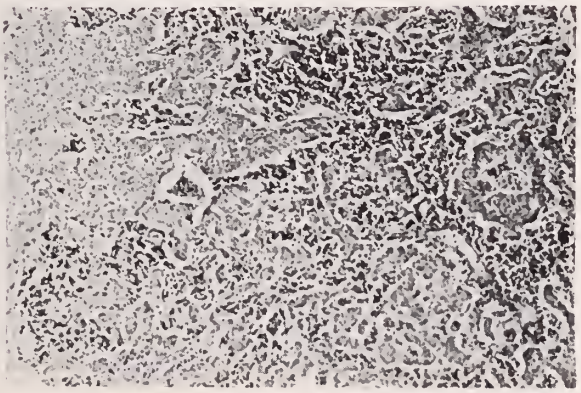

Figure 9—Case 3. August 1973. Right axillary lymph node metastasis despite only carcinoma in situ found in right breast.

The third case is that of a 42-year-old woman who presented herself with a tumor of the left breast in July 1962. Eight years later, in November 1970, she returned with a tumor of the same breast. A review of the 1962 slides showed lobular carcinoma in situ. Now eight years later, November 1970, we have invasive lobular carcinoma with metastasis to the axillary glands. We did a radical mastectomy and followed it postoperatively with orthoradiation therapy. Thirteen months later, December 1971, this patient returned with subcutaneous nodules of lobular carcinoma in the area of radiation therapy and the opposite chest wall. At this point the patient was given 5-fluorouracil. She tolerated this for one year before she refused further treatment because of illness she endured after each dose of 5-fluorouracil.

During this treatment she developed pain in the left hip. She received no specific treatment for seven months and on return for a follow-up examination a nodule was felt in the remaining breast. This was removed and found to be lobular carcinoma in situ. A modified radical mastectomy was performed. Lobular carcinoma in situ was found throughout the breast and despite no invasive carcinoma being found in the breast, metastatic lobular carcinoma was present in the axillary nodes.

This patient is now receiving testosterone. It is much too soon to judge its effect, except that she has experienced great relief to her painful hip which shows bony sclerotic changes consistent with metastatic carcinoma.

The fourth case was an 82-year-old woman who had tumors of both breasts. In 1967 these tumors were excised by what is often called a simple mastectomy (where most of the breast tissue is excised). A report of fibrocystic disease in both breasts was obtained from these biopsies.

Three and a half years later (1970) this patient returned with recurrent tumor in the right breast. Mammograms were taken and interpreted as large cystic masses and not carcinoma. A review of the old slides showed lobular carcinoma in situ.

The original examinations of these four cases were made by four different pathologists, not just one. This is a reminder of how difficult this serious disease is to diagnose.

Three years later this woman had lobular invasive carcinoma with bony metastasis. After biopsy proof was obtained, she was placed on testosterone and made an unbelievable recovery. From being bedridden and complaining of severe pain, she was up and about pain-free. Very interestingly this patient, after several months, refused further injections of testosterone. She very quickly began to deteriorate and returned for further treatment. In spite of receiving benefit the second time, she stopped her treatment, and death resulted due to the disease.

Summary

This is a benign-appearing tumor which does become invasive. It is multifocal so that excisional biopsy or the modern "lumpectomy" does not cure the disease. It occurs in both breasts with such high frequency that very great care must be followed with the remaining breast. Some advocate quadrant biopsies be taken in the opposite breast if no tumor is palpable. I feel frequent examinations with biopsy of palpable tumors to be sufficient but also that bilateral mastectomy for this disease is accept-

able. Great care must be exercised by the pathologist, as small foci may be hidden in fibrocystic disease. The surgeon should not feel upset if negative frozen sections prove positive in subsequent permanent sections. I believe that sufficient study of this tumor now exists, and that for lobular carcinoma in situ simple mastectomy is the treatment of choice, reminding you that a simple mastectomy is not so simple. You must remove all breast tissue, as this is multifocal disease.

From our experience, the response of the invasive lobular carcinoma to testosterone has been very gratifying. Roentgen therapy seems to have little or no effect on the course of the tumor. Our experience with 5-fluorouracil does not lead to any conclusion.

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JOSEPH M. KING ***Festschrift***

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Wise Counsel

Dr. Joseph M. King was a founder member of the Milwaukee Academy of Surgery and was President in 1966 in its third year. He has provided leadership in the community and helped to train many of the surgeons still active in Milwaukee and Wisconsin.

Throughout the years it has been the privilege of young surgeons to listen to his wise counsel and discussions of problems at scientific sessions. Even after his retirement his presence at meetings has brightened the atmosphere with his smile.

On behalf of the Milwaukee Academy of Surgery, I express sincere appreciation and gratitude for his contributions to our development.

—SHIMPEI SAKAGUCHI, MD, Milwaukee
President, Milwaukee Academy of Surgery

Salute to Joseph M. King

The membership of the Wisconsin Surgical Society salutes Dr. Joseph M. King, Honored Founder Member, Distinguished Past President, and Active Leader of the association on the occasion of this greatly deserved Festschrift of the *Wisconsin Medical Journal.*

In 1946 Doctor King, in conjunction with 50 other Wisconsin surgeons, formed the Wisconsin Surgical Society dedicated to the memory and ideals of William Beaumont (1785-1853), particularly endeared to our State because of his encounter with Alexis St. Martin while stationed at Mackinac Island and Fort Croix. Although Doctor King's forte was not research, his 40 years of service to the Milwaukee County Hospital, 27 years as Director of Surgery, saw the development of that hospital into a ranking national institution. At the same time, in his capacity as leader in the Wisconsin Surgical Society, his name became synonymous with honesty in surgery, outstanding morality in practice and the observation of strict medical discipline and the conduct of patient care and physician relationships.

The young surgeons of this State owe a great debt of gratitude to Doctor King and his confreres for the excellent professional climate available to them in this State for surgical practice.

Although Doctor King resigned from his surgical duties in 1962, his interest in education, surgery, and the Wisconsin Surgical Society has continued unabated. Both he and his lovely wife (the former Irene Riordan) have been constant attendees at the Society meetings during the past 10 years.

The Society wishes them well and continued health and happiness.

—WILSON WEISEL, MD, Milwaukee
President, Wisconsin Surgical Society

Management of Massive Gastroduodenal Hemorrhage in the Trauma Patient

JOSEPH C. DARIN, MD, Milwaukee, Wisconsin

MASSIVE HEMORRHAGE from ulcers of the duodenum and stomach is a life-threatening complication of trauma and surgery. The importance of stress in the genesis of peptic ulceration is well recognized, but the physiological mechanisms of ulcer production are poorly understood. Although there has been considerable interest in the problem from the research point of view, clinical reports have been sporadic and contain only a small number of cases. Publications concerned primarily with the problem of hemorrhage from "stress ulcers" following trauma and operation are usually of the single case report variety. A recent report of 35 cases of gastroduodenal hemorrhage following unrelated surgery documented a 71 percent overall mortality rate.[1]

This report is an analysis of a four-year experience with the problem of massive gastroduodenal hemorrhage following trauma or unrelated surgery. The stress of external and surgical trauma is assumed to be of a similar nature. This fact and the knowledge that most trauma patients undergo surgery prompted us to include both post-traumatic and postoperative patients in this report.

For purposes of this report, cases of terminal gastroduodenal hemorrhage seen in postoperative cancer patients, post-craniotomy patients with tumor, massive head injury patients, and cancer chemotherapy patients are excluded.

The definition of "massive" hemorrhage is of importance in statistical reporting. Although the definition of massive hemorrhage as outlined by Stewart[2] has aided in the evaluation of different reports, there still exists the problem of evaluating results because one cannot ascertain if patients undergoing "emergency" surgery are actively bleeding at the time of surgical intervention. The surgical mortality rate in those cases in which active bleeding is present is significantly higher than in those undergoing urgent surgery for a recent massive hemorrhage.[3]

Our definition of massive hemorrhage is as follows: The patient must exhibit signs of active bleeding. At least one of the following must also be present: (1) evidence of a decreased blood volume as estimated by a hemoglobin value of less than 8 gm or a hematocrit of less than 25; (2) shock; (3) hypotension of at least 40 mm of mercury below an established normal; and, (4) a measured loss of at least 500 ml of blood. Massive hemorrhage is also present in the patient with a recent rapid hemorrhage, without the above criteria, after 1500 ml of whole blood is administered.

TABLE 1 — *Primary site of operation or trauma in thirty-nine patients with massive gastroduodenal hemorrhage*

Site	Number of Patients
POST-TRAUMATIC:	
Chest	7
Orthopaedic	8
Abdominal	1
Neck	1
POSTOPERATIVE:	
Biliary tract	6
Genitourinary tract	5
Chest	3
Colon	2
Pancreas	2
Sympathectomy	1
Hernia	1
Other	2

Material

In the four-year period from 1960 to 1964, there were 39 cases of post-traumatic and postoperative massive gastroduodenal hemorrhage seen at Milwaukee County General Hospital and Wood Veterans Administration Hospital. The primary site of operation or trauma is listed in Table 1. Thirty-two patients were men and seven were women. Their ages ranged from 26 to 95 years, with an average age of 60 years. All of these patients met the above-mentioned criteria for massive hemorrhage. In the surgically treated group, all patients were actively bleeding at the time of surgical intervention.

Onset of Hemorrhage

Hemorrhage occurred in all patients from 1 to 16 days after the primary insult. Eighty percent of the patients started to bleed within the first 7 post-stress days. The post-traumatic patients bled earlier (average four days) than the postoperative patients (average 7 days). The initial episode of hemorrhage was manifested by hematemesis and/or melena in 36 patients. Two patients were found in shock and

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one complained of weakness and was pale. The severity of the hemorrhage is evidenced by the average of 6,500 ml of whole blood administered per patient.

Treatment

The method of non-surgical care was by no means standardized; however, rapid blood replacement to normal levels, a modified Sippy regimen with antacids in those who were able to ingest fluids, sedation and bed rest were routine in patients without active hematemesis. In those with hematemesis, nasogastric suction was utilized for the patients' comfort, as protection from aspiration and as an aid in estimating blood loss. Adequate blood replacement was judged by measurement of losses, return of pulse to normal and frequent hemoglobin and hematocrit determinations. Hemoglobin and hematocrit levels in patients with a rapid rate of hemorrhage are not always useful during the first few hours of bleeding. In those with prolonged hemorrhage, hemoglobin and hematocrit determinations are useful. We do not believe in using anticholinergic drugs because of their effect upon pulse rate which is probably the most useful clinical sign of adequate volume replacement. Central venous pressure monitoring was used in many patients.

Criteria for Surgical Intervention

One-third of the patients had emergency surgery performed for massive hemorrhage. These patients can be classified according to criteria that led to the decision of emergency surgical intervention:

1. Exsanguinating Hemorrhage: Immediate Surgery

Patients with exsanguinating hemorrhage are those in whom vigorous blood replacement does not maintain a stable blood pressure and pulse. Patients who are losing an estimated 500 ml or more every 8 hours, as determined by hemoglobin, hematocrit, pulse and pressure levels after transfusion, are also classified as exsanguinating patients and are operated upon.

2. Continued Hemorrhage: Surgery Performed 24 Hours After Onset

If active hemorrhage continues for more than 24 hours while the patients are under vigorous medical therapy, they are classified as having continued hemorrhage and undergo surgery.

3. Recurrent Hemorrhage: Surgery Performed After Second Hemorrhage

If active hemorrhage recurs during the same hospitalization and while under active care, surgery is carried out as soon as the blood volume is restored or immediately if the recurrent hemorrhage is exsanguinating.

Of the total of 13 patients who underwent emergency surgery, 7 (54%) continued to bleed for more than 24 hours, 4 (31%) had exsanguinating hemorrhage and 2 (15%) were operated upon for recurrent hemorrhage. In a series with this small number of patients, it is difficult to sensibly analyze factors such as mortality in relationship to the type of hemorrhage.

JOSEPH M. KING
Festschrift

WISCONSIN MEDICAL JOURNAL
November 1973/Part 1

Analysis of Deaths

Medical Treatment

There was a total of 26 patients who were not operated upon for their gastroduodenal hemorrhage and 13 (50%) died. There was no significant difference in mortality rates between the post-traumatic and postoperative groups, each of which contained 13 patients. In a retrospective analysis, it is difficult to criticize the treatment, especially where judgment decisions are concerned. Many factors play an important role in the death of these patients.

The average age of the 13 patients who died without surgical intervention was 59 years. Their ages ranged from 26 to 95 years. In attempting to find where our criteria for operative intervention were violated, we found that 7 of these 13 patients continued to bleed for more than 24 hours. The majority of these patients died from secondary organ failure due to prolonged volume deficit. Three of these patients were post-traumatic and had severe injuries of the chest and neck. All three were relatively young, their ages ranging from 34 to 51 years.

Surgical intervention was not entertained in the hopes that the hemorrhage would stop and emergency surgery would not be necessary. There is little question that all 3 patients, in spite of their having major injuries, should have had early emergency surgery performed. The other 4 patients with continued hemorrhage were recovering from operative procedures for hernia and genitourinary disease. Three were 65 years of age or older. All 4 patients should have had surgical intervention entertained.

In the final analysis, these 7 patients with continued hemorrhage were not given the benefit of vigorous therapy which would have included emergency surgery in most instances. The thought that the complication of massive gastroduodenal hemorrhage following trauma cannot be successfully treated surgically is a fallacy.

Four of the 13 medical deaths died of exsanguinating hemorrhage. Two bled following trauma. They died within 5 and 8 hours after the onset of hemorrhage. Both of these patients should have been

TABLE 2 — *Operative procedure in thirteen cases of post-traumatic and postoperative hemorrhage*

Operation	No. of Patients	Deaths
Ligation, pyloroplasty and vagotomy	5	0
Hemigastrectomy and vagotomy	3	0
Partial gastrectomy	4	1
Simple ligation only	1	1

considered for emergency surgical intervention. The other 2 patients with exsanguinating hemorrhage followed a transurethral resection and a cholecystectomy-choledochotomy. The 2 patients who died of recurrent hemorrhage were both post-traumatic. Their injuries, although severe, should not have deterred from the decision for surgical intervention.

I have the impression that in most of these patients the thought of emergency surgical intervention was not seriously entertained because of the feeling that altered physiology secondary to operation and trauma was of such severity to prevent the patient from successfully undergoing emergency surgery. The answer to this is a very simple one; that is, the number of patients with conditions just as severe who underwent surgical intervention with success.

An analysis of the 13 patients who survived without surgical intervention shows some interesting data. The average age of these patients was considerably higher (65 years vs. 59 years). This is in opposition to the common belief that the older patient is most likely to continue bleeding. When we apply our criteria for surgical intervention to this group of patients, we find that in only three situations were the criteria violated. Two patients continued to bleed for more than 24 hours and one patient stopped after a recurrent massive hemorrhage.

Surgical Treatment

A total of 13 patients underwent emergency surgery for control of their massive gastroduodenal hemorrhage with only two deaths (15%). There was little difference in mortality between the post-traumatic and postoperative groups. The type of surgical procedure is listed in Table 2. The average age of the surgical group was 57 years. The patients who died were 58 and 45 years of age.

The 58-year-old patient who died following simple suture ligation of a duodenal ulcer began bleeding one day after a lobectomy for carcinoma of the lung. His nonsurgical management did not follow our criteria because the first episode of hemorrhage was continued longer than 24 hours. His hemorrhage stopped only to restart again massively. Again, the patient was allowed to bleed for a prolonged period of time. During the interval, he developed a gram-negative septicemia secondary to a bronchopneumonia. Finally, some seven days following surgery, he was explored. He died of continued hemorrhage and septicemia. At autopsy, recurrent ulceration of the distal end of the stomach and duodenum was found. One can assume that the addition of an adequate pyloroplasty and vagotomy might have prevented further hemorrhage, and if surgery had been performed earlier, a favorable outcome might have occurred.

TABLE 3 — *Location of ulceration in thirty-nine patients with gastroduodenal hemorrhage*

Site	Number of Patients Nonoperative Rx	Operative Rx
POST-TRAUMATIC:		
Duodenal	3	1
Gastric	6	2
Assumed superficial	6	—
POSTOPERATIVE:		
Duodenal	2	3
Gastric	5	7
Assumed superficial	4	—

The 45-year-old man who died following a partial gastrectomy began to bleed 12 days after incurring multiple open fractures. The criteria for surgical intervention were violated since the man was allowed to have continued hemorrhage for 48 hours before emergency surgery was performed. A 65 percent partial gastrectomy with a Billroth II type of reanastomosis was performed. The immediate cause of death was a ruptured duodenal stump and generalized peritonitis. This patient was allowed to bleed for a prolonged period.

It is well known that surgical mortality rises, as pointed out by Finsterer[4] many years ago, if the hemorrhage is allowed to continue beyond 24 hours. Second, this patient is classified as a technical cause of death in that the immediate cause of death was peritonitis secondary to a rupture of the duodenal stump. We have found in our recent experience with massive gastroduodenal hemorrhage that "operative conservatism" plays an important role in the reduction of surgical mortality. In our 1960 report,[5] we noted that 50 percent of the deaths were due to technical errors such as blown duodenal stumps, gastroenterostomy leaks, injury to the pancreas, and retained ulcers. In our recent experience, the use of pyloroplasty and vagotomy when distinct ulcer is present, especially in the aged, or the use of conservative resection and vagotomy for diffuse superficial ulceration has markedly reduced the surgical mortality rate.

We feel quite strongly that the utilization of the least amount of surgery required to stop the hemorrhage and prevent recurrent ulceration is the major reason for our reduction of surgical mortality.

Pathology

The location of the peptic ulceration is noted in Table 3. The diagnoses in the surgical group were all proved at the time of surgery or autopsy. The diagnoses in the nonsurgical group were proved by roentgenologic examination or autopsy. If the x-ray examination was negative, it was assumed that the

patient had a superficial ulcer of either the stomach or duodenum.

In the entire group of 39 patients, there were 9 proven duodenal ulcers and 20 proven gastric ulcers. Ten patients, all survivors treated nonoperatively, did not have ulcers seen on x-ray examination. There is relatively little difference in the incidence of either type ulcer in the post-traumatic and postoperative groups. Further analysis of the patients with either duodenal or gastric ulcers failed to reveal any significant difference in mortality. The onset of hemorrhage in the duodenal ulcers was earlier than the gastric ulcers. Two of the duodenal ulcers and two of the gastric ulcers were thought to be chronic and to have been present prior to the initial trauma. All 4 had a previous history of peptic ulcer. Multiple duodenal ulcers were seen in one patient, whereas multiple superficial gastric ulcers were present in 13 patients.

Genesis of Stress Ulcers

Although Curling[6] is given credit for first describing acute peptic ulceration following severe stress, it probably was originally noted by Swan[7] in 1823. So-called "Curling's ulcers" seen in the stomach and duodenum of thermally injured patients have a quite different histologic appearance and probably have a different pathogenesis.[8]

Ever since Cushing's[9] report in 1932, in which he described peptic ulcer in association with midbrain lesions, there has been great interest in proving a neurogenic mechanism mediated through the vagus. Many studies have been done attempting to demonstrate a relationship between stress and hypersecretion. Drye and Schoen[10] found gastric hypersecretion following trauma, but were unable to demonstrate increased circulatory adrenocorticoids. They thought that ulceration was due to lack of gastric buffers rather than hypersecretion per se.

We are inclined to agree with this supposition from a clinical viewpoint, especially with the knowledge that many of our cases had prolonged postoperative ileus. Ileus would inhibit such buffer mechanisms as ingestion of food and duodenal regurgitation. It would also contribute to distention of the gastric antrum and trigger the gastric phase of acid secretion.

Summary

Thirty-nine cases of massive gastroduodenal hemorrhage following trauma or unrelated surgery have been reviewed. Thirteen patients had emergency surgical intervention with a mortality rate of 15 percent. The mortality rate was 50 percent in the 26 patients not operated upon.

Massive gastroduodenal hemorrhage should be attacked vigorously with surgical intervention guided by specific criteria. "Operative conservatism" with the use of suture ligation, pyloroplasty, and vagotomy or hemigastrectomy and vagotomy has reduced the operative mortality.

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JOSEPH M. KING ***Festschrift***

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Everything Under Control

My first teacher in clinical surgery was Dr. Joseph M. King. He bears from me the highest respect and admiration. Outwardly, on first meeting, he seemed short and to the point. In the cumulative daily relationships, he was kindly and benevolent. A proficient surgeon with compassion for his patients, he was intensely proud of his residents, possessed with absolute ethics and impeccable honesty. New Year's eve at the old Milwaukee County Emergency Hospital, was a "battle ground" receiving station of trauma and illness. On that special night, there were always extra complements of physicians, nurses, and orderlies. Each had an assignment, and all gave their full measure. On one New Year's Eve, as he was on many such eves, Dr. Joe King was preeminent—there to help. Patients with lacerations were inundating the area. It was just after midnight when Doctor King said to me, "Paul, just keep sewing, and I'll go over all the bellies and check the x-rays." Two hours later the King Group had everything under control!

—Paul Natvig, DDS, MD, Milwaukee

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Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

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Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

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STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 11 NOVEMBER 1973

FROM THE PRESIDENT

To Joseph M. King, MD

THIS FESTSCHRIFT ISSUE dedicated for the eighth time to one of the giants of medicine in Wisconsin is appropriate and timely.

This dedicated servant of mankind is and has been an example to his many residents and physician friends throughout his long and fruitful life. His hallmarks are kindness, compassion, discipline, and service to others applied to teaching and the practice of medicine. A leader of men. A venerated and respected physician to his many patients. Coupled with his many attributes is a strong faith in his fellow men and faith in our Lord.

It is during this time of political unrest and increasing political pressure for social and medical change in our society that pillars of strength and dedication stand out. Doctor King's contributions and examples are for all to see. His influence on society, medicine, and patient care in Wisconsin is a shining example at a time when the fundamentals of medical practice are being threatened.

To this physician, humanitarian, educator, and friend—our best today and in the future, and a thanks for being one of us.

G. J. Devus M.D.

THE COUNCIL

FALL MEETING

New Society Positions, Policy

A jam packed agenda took up the full November 3-4 weekend for the State Medical Society's Council. A number of position statements on such things as acupuncture, chiropractic inroads, and federal regulations appear elsewhere in this issue. A run-down of other major agenda items:

CONTINUING MEDICAL EDUCATION ACCREDITATION PLAN: Some 200 community hospitals, institutions, and organizations across the state are potential sources of continuing medical education programs. How can the physician be sure of the quality of many of them?

If its application to the AMA is approved, the State Medical Society will start an accreditation program for local continuing medical education in the state. The Council approved the application to the AMA prepared by the Commission on Scientific Medicine.

The Society would fund its accreditation work basically by charging those who use the service: applicant hospitals and other local organizations. Other funds are likely to come from such sources as pharmaceutical firms and educational foundations as well as the Society's treasury.

The guideline for the work will be the *AMA Essentials of Approved Programs in Continuing Medical Education*. Any institution or organization which is dissatisfied with the Society's accreditation action will be able to appeal through the review committee, the Commission on Scientific Medicine, and the Council.

OFFICE PRACTICE MANAGEMENT WORKSHOP: Typically, the physician spends only 50% of his working time actually seeing patients. Medical recordkeeping, detail men, the telephone, administration, and the myriad of other demands on a physician's working day eat away the rest.

In cooperation with the AMA, the State Medical Society is planning to offer a practice management workshop designed to improve this ratio. "Establishing Yourself in Medical Practice," a two-day workshop, is designed to help particularly those physicians just beginning medical practice.

It covers work flow procedures, practice organization, and personnel utilization. Dates will be announced soon. As the workshop is limited to 25, preference will be given to Society members who are finishing their residency training.

PUBLIC RELATIONS FOR COUNTY MEDICAL SOCIETIES: Physicians and the practice of medicine are topics that have been increasingly dealt with by the mass media in recent years. Sometimes physicians do not approve of the way this information is handled. Inaccuracies or adverse treatment of a medical subject often point up the need for well organized physician public relations programs at all levels.

To aid county medical society public relations programs, the State Medical Society will offer a public information seminar during the Annual Meeting. It will be open to all members of the Society and will be particularly helpful to members of county medical society public relations committees.

SECTION ON NEUROLOGY: There are now 44 Board eligible and Board certified neurologists practicing in the State of Wisconsin. They have formed a Wisconsin Neurological Society to update their own knowledge. Now, the State Medical Society's Council is recommending to the House of Delegates at their request, that separate scientific sections be created for neurology and psychiatry. Formerly, neurology was represented by the Section on Neurology and Psychiatry.

BASIC SCIENCE LAW: Basic science exams for physicians seeking licensure are gradually being eliminated across the country. However, in Wisconsin the examination is still used, both for physicians and chiropractors. At the recommendation of the Ad Hoc Committee on Chiropractic, the Council reaffirmed the Society's position in favor of retaining the current Wisconsin basic science law "in the interest of maintaining the current high standards which exist in the state."

PRICE CONTROLS

Relief in Sight?

At its fall meeting November 3-4, the State Medical Society's Council outlined its position on continuing economic controls on health-care providers. Here is the council's statement.

* * *

The Economic Stabilization Program (ESP) begun in August 1971 was designed by the Administration to control the American economy's accelerating rate of inflation. At that time physicians throughout the country publicly acknowledged their responsibility to work toward the Administration's economic goals while at the same time preserving the highest possible standard of quality medical service. The record of physicians in voluntarily "holding the line" on fee increases during the voluntary phases of the stabilization program was eminently successful and widely acknowledged. In a similar fashion, physicians performed conscientiously in controlling charges as the program moved through Phases I to III.

After performing successfully under both the voluntary and regulatory phases, and especially Phase II of the ESP, the medical profession was astounded and deeply concerned when it was continued under mandatory controls in Phase III. Other sectors of the economy even in the service fields had not performed as effectively but were rewarded with voluntary controls in Phase III.

The President announced that one of the main elements in the Phase IV policy is that the regulatory system must be selective so that it will "not waste effort on sectors of the economy where stability of price exists." By any fair appraisal of the situation, physicians fall into this category and therefore deserve to be removed from the ESP's mandatory price controls.

At present physicians find their office operation costs increasing rapidly as those aspects of the economy are removed from control while their ability to make fee increases is limited to 2.5% annually, provided those increases do not raise their profit margin. Physicians in professional service corporations are unable to raise salaries

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

NOTE: The Cost of Living Council has announced new fee guidelines for physicians which in many respects meet the requests of the SMS Council and the AMA.

above 5.5% even though revenues have increased as a result of greater productivity and larger work loads.

The State Medical Society of Wisconsin supports intensive efforts of the American Medical Association to convince the Cost of Living Council and its health industry advisory committee to remove mandatory controls on physicians. It supports at the state level the AMA's pledge to exercise leadership on behalf of the medical profession to ensure effective voluntary cost controls, to voluntarily limit fee increases, voluntarily hold profit margins to current levels except under extenuating circumstances, and to voluntarily conduct educational programs encouraging physicians to utilize less costly facilities, tests, and procedures where these can contribute to holding the line on the costs of care.

The Council of the State Medical Society urges that the American Medical Association continue in every way possible, including litigation, to eliminate discriminatory economic controls on health care providers. If controls cannot be made voluntary, there should be substantial alterations in the fee increase limitations to extend the annual fee increase limit to something in the vicinity of 4 to 6%. If controls are to remain in effect, the philosophy must be continued that permits physicians to increase fees on an aggregate basis rather than a unit basis.

As the Cost of Living Council and its advisory committee move toward adoption of Phase IV guidelines for the health care sector, the Council urges the AMA to continue its efforts, and if these are unproductive, to be ready to advise its individual members in concert with state and county medical societies on alternative methods that might seem appropriate to achieve relief from discriminatory cost controls. The Council recommends that the Society use every reasonable means at its disposal, including contacts with appropriate government agencies and the Wisconsin Congressional delegation, to achieve a more favorable position under price control regulations. ☐

ETHICAL ASPECTS OF PR ACTIVITIES OF HOSPITALS AND CLINICS: The widespread employment of public relations-development persons in hospitals and clinics, the growth of "health maintenance organizations" which desire to make known their availability, and lower occupancy rates in hospitals all have combined to present a new ethical problem for physicians. Newsletters from health care institutions are proliferating and occasionally the editors, in their enthusiasm about their institutions, use comparisons to other institutions or references to physicians which conflict with the prohibition against solicitation of patients.

The Council has asked the Commission on Health Information to develop guidelines in conjunction with representatives of the Wisconsin Hospital Association and those who are involved in the actual production of such publications. After such guidelines are developed, it is hoped that this committee could continue as a review board and as an advisor to health-care organizations and media throughout the state.

AD HOC NURSE LIAISON COMMITTEE: The Council approved a new name for this committee: Joint Practice Committee of the State Medical Society of Wisconsin (SMS) and the Wisconsin Nurses Association (WNA). The Council also approved the following statement of purpose for the committee:

> The Joint Practice Committee of the SMS and WNA has been established to enhance health care for the people in Wisconsin through collaboration between physicians and nurses and more effective utilization of their services. Toward achievement of this purpose the committee will:
>
> 1. Develop a joint practice statement for consideration and adoption by the State Medical Society of Wisconsin and the Wisconsin Nurses Association.
> 2. Develop recommendations, as appropriate, regarding education, legislation, practice arrangements, and delivery patterns.
> 3. Encourage demonstrations aimed at improving health care delivery through the collaboration of physicians and nurses in concert with other health workers and the recipients of care.
> 4. Facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles, and practices.
> 5. Serve as a consultation resource for the SMS and WNA in matters that relate to joint practice.
> 6. Cooperate with the Joint Practice Commission of the American Medical Association and the American Nurses Association.

COMMITTEE ON PEER REVIEW: The federal government is generating additional physician paperwork for Medicaid patients in nursing homes. Involved is certification of need for inpatient care, a written plan of care and utilization review (see September GREEN SHEET). Some of the forms proposed have incurred the displeasure of several physicians as well as elements of nursing home administration. The Council is now requesting the state Department of Health and Social Services for an opportunity to have continuing direct State Medical Society involvement in the developing application of these new requirements in Wisconsin, preferably through its Committee on Peer Review.

COMMISSION ON MEDICAL CARE PLANS: Two 1973 House of Delegates resolutions acted on by the Commission are:

RESOLUTION AA: **Title XIX Claims Handling**—Called for one copy of a vendor's Title XIX claim form to be returned to him with indications as to which services or supplies were paid for and which were not, the reasons for nonpayment, and the amounts of money paid. This was done on an experimental basis but proved unworkable. The additional paper flow was objectionable in the physician's office and resulted in a too costly method of notification. Currently, HEW and the state Medicaid office are considering a total payment notification similar to the Medicare system.

RESOLUTION M: **Current Procedural Terminology (CPT)**—Directed that WPS accept claims coded by this system and that SMS encourage its utilization by physicians and insurance carriers. WPS now accepts claims submitted using CPT. Thus far the number of physicians' offices using this system is minimal.

COMMISSION REPORT: Three hospitals are now using a new WPS reimbursement system. The hospital can confirm promptly by telephone

the subscriber's coverage, and upon discharge write a check on a WPS bank account equal to its contract liability. Payment delays are avoided, paper work is reduced, and subscribers are impressed with prompt WPS service. Claims are post-audited rather than screened prior to payment. For the resultant cost saving, these hospitals have agreed to a reduced charge to WPS.

PHYSICIAN ASSISTANT LEGISLATION: How this new law is applied will depend in part on PA training and practice standards recommended to the Medical Examining Board by a physician assistant council.

This 15-member council, including two practicing physicians selected by the Medical Examining Board, must be operational and submit a progress report by Feb. 1, 1974. The Society's Council has authorized the reactivation of the Society's physician assistant committee during the implementation period of this new law.

SECTION ON OPHTHALMOLOGY: The inclusion of optometry in the WPS Vision Care Plan has drawn a number of objections from the Society's Section on Ophthalmology. The Council directed the Commission on Medical Care Plans to work closely with representatives of the Section on Ophthalmology and to utilize the services of an advisory committee in making presentations to group insurance purchasers so as to more clearly explain the differences between medical eye care and optometry. □

SMOKING

Hazardous to Your Health

The Society is under increasing question from the public, including legislators, as to its position on smoking. This was especially illustrated in the recent legislative hearing on a bill introduced by Representative Joanne Duren, Cazenovia, to prohibit smoking in hospitals and medical clinics.

The Society supported her efforts in principle, but felt the need to clarify its previous actions and policies with the following position statement. The statement was approved by the Council November 4.

The House of Delegates of the American Medical Association in 1964 declared that the AMA recognizes "a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases, and that cigarette smoking is a serious health hazard." In 1968 the AMA House of Delegates adopted a resolution that the AMA "urge its members to play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking, discourage smoking by means of public pronouncements and educational programs, and take a strong stand against smoking by every means at its command." Many scientific and voluntary health organizations have taken vigorous action in condemning smoking as a health hazard.

The State Medical Society has for many years refused to accept cigarette advertising for publication in the WISCONSIN MEDICAL JOURNAL.

The Society has for many years refused to display exhibits of tobacco companies which in any way promote the use of tobacco or smoking.

The Society, through its Committee on Cancer, has officially requested the American Hospital Association to urge its Wisconsin members to remove cigarette machines from their hospitals. The Society has removed cigarette machines from all its premises. During such meetings as the Work Week of Health, for example, it requests no smoking in meeting rooms out of respect for the rights of nonsmokers who may be in the audience.

The State Medical Society recognizes that cigarette smoking is hazardous to the health not only of the smoker but also of the nonsmoker who is required to inhale the air contaminated by his smoker-neighbor. It also recognizes the right of the smoker to choose to smoke, but believes that such a person must not infringe on the equal rights of those who choose not to smoke.

The Society strongly discourages smoking as a health hazard of a serious nature. Out of consideration for the growing number of persons who for health or other personal reasons choose not to smoke, the Society encourages no smoking policies in public areas such as medical offices, hospitals, elevators, libraries, theaters, and museums, but suggests that a practical alternative to outright prohibition is the establishment of smoke-free areas for nonsmokers in all public indoor facilities including medical offices and hospitals, restaurants, theaters, mass transportation vehicles, and meeting rooms. □

MESDAMES MEISINGER AND JOHNSTON with samples of Auxiliary wigs

AUXILIARY

A Hair Raising Project

One of the unfortunate side effects of many types of cancer treatment is loss of hair. Particularly to a woman, this side effect can be almost as distressing as the illness itself.

To help women with this and other medical problems causing hair loss, the Woman's Auxiliary to the State Medical Society has collected wigs and is distributing them free. With the help of the American Cancer Society—Wisconsin Division, hospitals and nursing staffs throughout the state have been told that wigs, wiglets, and hairpieces are available to any patient needing one for any medical reason.

Requests can be handled by any county Woman's Auxiliary or by contacting:

Mrs. George Meisinger
Route 3, Box 233 C
Fond du Lac, Wis. 54935
or
American Cancer Society
Wisconsin Division
Box 1626
Madison, Wis.

There are over 1100 wigs in the Auxiliary collection and Auxiliary members will match the patient's hair color if a small sample is sent. Prestige Beauty Schools throughout the state wash and style the wigs as the patient wishes.

The project was started earlier this year by Woman's Auxiliary President Mrs. Robert Johnston, Green Bay. □

Two More Chiropractic Targets

Fresh from having won chiropractic inclusion under Medicare, chiropractors are now pushing for two more pieces of federal funding: Medicaid and examinations of truck drivers.

The State Medical Society's Council adopted statements at its fall meeting in response to both attempts.

While some federal regulations are limiting Medicaid payments to physicians, others are getting ready to broaden Medicaid to include chiropractic. Here is what the Society's Council had to say on that subject.

The Social and Rehabilitation Service of the Department of Health, Education and Welfare has proposed tentative regulations which relate to standards for the provision of chiropractic services under Medicaid where the states have chosen to include such benefits in the Title 19 program. HEW proposes that the same regulations apply to chiropractic under Medicaid as have previously been established for such benefits under Title 18-Medicare.

The State Medical Society strongly opposes the inclusion of chiropractic services under Medicaid. It believes that the standards under which chiropractic benefits are permitted under Medicare are totally inadequate for the protection of the public and that this dangerous precedent should not be permitted to continue or be extended under Medicaid. The Society urges that the Congress enact specific legislation denying federal participation in Medicaid payments to chiropractors. In the meantime, the standards for chiropractic services under Medicaid if allowed by any state should not involve federal participation unless the standards are substantially strengthened and restricted beyond those presently afforded under Medicare. The standards for Title 18 programs are at the most extremely limited and minimal and should not be regarded as adequately protecting the public interest.

The Society equally vigorously opposes the proposed extension of chiropractic benefits to federal rehabilitative service programs. If the benefit is provided, the standards for those services must at a minimum be those of Title 18, and preferably much stronger and more definitive.

This position is to be communicated to the Department of Health, Education and Welfare and to the Wisconsin Congressional delegation.

Charles Wolter, Chiropractor, is palpating the cervical region of a patient to determine the vertebral misalignment causing nerve interference which results in functional disorders of the various organs.

NEWSPAPER CHIROPRACTIC AD

Next, Medicaid and truck drivers?

TRUCK DRIVER EXAMS

The Federal Bureau of Motor Carrier Safety has proposed that motor carrier safety regulations be amended to permit chiropractors to perform physical examinations of commercial vehicle drivers in interstate commerce. The federal agency has declared that the objective of the proposal "is to have drivers examined by medical examiners who are capable of diagnosing diseases, injuries, abnormalities, or other conditions which affect the ability to drive a heavy commercial vehicle safely."

The State Medical Society believes that no chiropractor is capable of performing a proper diagnosis such as required by this regulation. To accord such a privilege to chiropractors for truck drivers would inevitably lead to their examination of others engaged in interstate commerce, such as airline pilots —a possibility which the Society can only contemplate with great apprehension.

The Council directs that a strong protest to this proposal be lodged with the Bureau and the Wisconsin Congressional delegation. The Council concurs with the recommendation of the Ad Hoc Committee on Chiropractic that in addition to the above activity, the Society should seek to have the Wisconsin Motor Carriers Association file a similar protest with the Federal Highway Administration and other appropriate bodies. ☐

ACUPUNCTURE:

"An experimental medical procedure"

ACUPUNCTURE

Still in Limbo

According to reports from China, acupuncture is effective in a host of ailments from malaria to blindness due to glaucoma, and from appendicitis to hypertension.

In this country, however, acupuncture's use is still in limbo. As a means of providing both physicians and the public with some guidelines, the State Medical Society's Council has adopted a statement on the use of acupuncture, as follows:

The use of acupuncture to relieve pain and provide anesthesia for patients is an experimental medical procedure. Its use must be limited to licensed physicians and surgeons. It is strongly recommended appropriate training and technical expertise be acquired by the physician before attempting its use.

The physician must utilize his professional training and experience in determining the use of acupuncture for a patient only after a complete medical workup and the establishment of differential diagnoses of the patient's complaint.

It is recommended that the patient further understand that acupuncture is an experimental procedure at the present time, and that no guarantee can be or is made as to the success of this form of therapy, and that alternate forms of therapy, and the likelihood of their success in the treatment of their condition should be explained to them.

This statement was prepared by the Society's Commission on Scientific Medicine after a two-month study including a survey of national and state policies, review of available literature, and discussions with Wisconsin MDs currently using acupuncture. The matter will continue to be studied. ☐

LAW

Pronouncement of Death

When is the physician actually required to be present for pronouncement of death? The law (sections 69.39 through 69.41 of the Wisconsin Statutes) is not always crystal clear on this subject. Regardless of law, there is physician obligation as well.

To lessen confusion, the State Medical Society's Council has adopted the following statement.

* * *

As the average life span of the population continues to increase, there will be more older persons living in sheltered and extended care environments. Just as the physician must respond adequately in any medical diagnostic situation, so must he respond to the final diagnosis.

Death is a medical diagnosis, and requires a qualified person to make it. The Wisconsin law provides that pronouncement of death can be made either by a physician or by a coroner. This statement deals only with the role of the physician.

The physician may not delegate the responsibility of making the diagnosis of death; however, he does not always have to be physically present at the location of the deceased to make the diagnosis.

Upon his medical judgment, information provided to him by a competent observer may supply sufficient information to enable him to make an unquestionable diagnosis. If such information is incomplete or if the physician questions the competency of the informer, he must make the diagnosis in person.

Where death is expected and the family has been adequately prepared, the act of making the diagnosis of death based on a competent observer's information, without the physician being actually present or traveling to the scene, is appropriate.

However, where death is sudden or unexpected, the physician should travel to the scene and carry out obvious functions with respect to the deceased and survivors.

While it is not mandatory as a matter of law that the physician always be present at the time of death or even that he respond by visiting the scene of death, good professional standards usually indicate a visit by the physician. This is true even in cases where he can positively make a medical diagnosis based on information supplied to him by a competent observer.

To preserve the patient-physician relationship, the physician should take such action as will reasonably satisfy the survivors of the deceased. This is beyond strict legal requirements, but is strongly encouraged so that the physician will always represent the art and science of medicine at its best. □

Alert to Members!

DEADLINES
for 1974
ANNUAL MEETING
Events

January 24
Resolutions for the House of Delegates due in Secretary's office
(two months before First Session)

February
Early publication of the *Wisconsin Medical Journal* with inclusion of major portions of the Annual meeting program and summaries of the resolutions

March 23
Council meeting

March 24, 25, 26
House of Delegates sessions

March 25, 26
Scientific Program

SMS Committees *in action*

Involuntary Commitment. Division on Nervous and Mental Diseases, October 14, voted to explore the feasibility of developing guidelines which might be of assistance to judges in determining the dangerousness of patients with mental illnesses. It is anticipated that the Wisconsin Board of County Judges will be approached to see if such an effort is warranted.

Interscholastic Sports. Division on School Health, September 6, agreed that from the legal as well as the medical standpoint a minimum physical examination is good for all interscholastic sports. The Division further recommended that a physician be on call for interscholastic games and at the very least the school have an appropriate mechanism to reach a physician. The Division urged county societies to cooperate with the schools in adopting workable programs. □

FEDERAL REGULATIONS

Distressing Proportions

An appeal against the overwhelming tide of federal regulations affecting the physician's practice was issued by the State Medical Society's Council at its November 3-4 meeting. Here is the council's statement.

* * *

The unnecessary encroachment of federal government into areas of professional practice and the patient-physician relationship is expanding so rapidly and with such vigor as to cause deep concern to physicians throughout the State of Wisconsin. In recent months there have been many evidences that federal controls are taking on distressing proportions. Some examples are the regulations imposing arbitrary and unrealistic limitations on the payment of services for Medicare patients; new and unusual rules for payment of physicians' services to Medicare patients in teaching institutions; renal dialysis regulations under Medicare which provide payment for physicians through hospitals rather than directly under Part B; the discriminatory price control regulations affecting physicians, and the continued controversy over recertification of patients in various types of nursing homes, to name but a few.

Most of these regulations come about through agencies of the federal government charged with the implementation of federally funded programs. In many instances the proposed regulations are first made known to the profession by publication in the FEDERAL REGISTER, a process by which the people affected by such regulations are given only 30 days to respond.

The Committee on Economic Medicine recommends that the State Medical Society appeal to the American Medical Association to establish a system which would permit more rapid national and local response to proposed federal regulations; that both the State Medical Society and the AMA seek legislation which would extend the time for response from 30 days to 60 days, and to seek at the national level to establish some more effective means for assuring contribution of the practicing profession in the development of proposed regulations prior to their publication. □

UNIONS

Frustration and Concern

More and more Wisconsin physicians are becoming interested in joining nationwide union organizations. Like many of their colleagues across the country, they have become frustrated with third party intrusion into the doctor-patient relationship and concerned that the American Medical Association and state and county medical societies are not adequately coping with physicians' economic problems.

Until recently, unionism's effect has been mainly on the 150 physicians and dentists employed by the state. They are required by law to select a bargaining unit to represent them. This activity is under the general supervision of the Wisconsin Employment Relations Commission (WERC).

The State Association of Career Employees is seeking to represent physicians and dentists and has petitioned WERC to conduct an election for this purpose. (The Wisconsin Nurses Association has already been designated the bargaining agent by the state-employed nurses, pharmacists, dietitians, public health nurses, health educators, and therapists.)

Recently, some physicians in the Lincoln, Langlade, Oneida, and Vilas counties area have sought to establish an affiliation with the Nevada Physicians Union, AFL-CIO. This union is reported to have about 2,000 members nationwide. Its president is John L. Holmes, MD, Las Vegas.

Other physician unions have expressed interest in the Wisconsin area. These include the American Federation of Physicians and Dentists headquartered in Springfield, Mo.; the Union of American Physicians, Daly City, Calif.; and the American Physicians Guild of Florida.

The AMA's position is basically that it can do anything a "union" or "guild" can do and that a separate organization is unnecessary.

On November 4 the State Medical Society's Council adopted the following four points as a position paper on unions while agreeing to give the matter continuing study.

A. The State Medical Society of Wisconsin recognizes the right of its members to join physician unions or similar legitimate organizations of their choosing. The Council believes, however, that the achievement of both the professional and economic goals of physicians can be accomplished through the affirmative action programs of the American Medical Association, the State Medical Society, and its component societies. It believes that a separate organization of physicians identified as a union, guild, or similar term does not possess any particular legal or other advantages with which to serve the interests of physicians. The State Medical Society is informed that existing anti-trust laws would seem to prohibit organizations of self-employed persons from engaging in collective bargaining. Since most practicing physicians in Wisconsin are self-employed, this factor would appear to limit physician unions in the legal sense to the same activities presently undertaken by organized medicine.

B. The ultimate bargaining power of a union in the organized labor sense is the strike, boycott, or withholding of services. Such actions are regarded by the State Medical Society as unacceptable and unethical if they result in the denial of necessary and proper care to the patient. The legal effects of withholding services are uncertain, but refusal to provide emergency or complications resulting from delay in treatment undoubtedly present substantial professional liability problems.

C. Where appropriate socio-economic interests of physicians are jeopardized by situations involving hospitals, governmental agencies, insurance companies, or similar third parties, the State Medical Society and its component societies should be prepared to act like a union in achieving the desired goals. The State Medical Society should develop the capacity, if it does not already have it, to act effectively in this manner in advising its component societies and its individual members. In doing so, it should seek the advice and support of the American Medical Association. This position is based on the belief that the Society has as one of its important functions the protection of the professional and socio-economic interests of its members, and the further advice by competent counsel that whether acting as a union or a medical society, self-employed physicians are subject to the same legal restraints and prohibitions, and also have the same opportunities in seeking to protect their economic and other interests.

D. The State Medical Society expresses the belief that it has a proper concern to act on behalf of the socio-economic interests of its members; that it has been the tradition of physicians to provide medical services to people in accord with their needs; that physician unions are being formed in Wisconsin for the purposes of bargaining with employers and third party groups. The State Medical Society of Wisconsin deplores the adoption by physician unions of the withholding of services so common to other unions, and reaffirms the tradition of Wisconsin physicians in not withholding medical services or performing any act that will interfere with the public health and welfare. □

Christmas Cards

The State Medical Society, through its Woman's Auxiliary, is making available this year Christmas cards with Wisconsin Medical themes that have been prepared over the past few years. See information on page 47 and order form on page 59. □

TV

"The Killers," five wide-ranging programs on the major lethal medical conditions in America, aimed at showing the healthy person how to stay that way, began November 19 on the state educational television network. This includes: Channel 10, Milwaukee; Channel 21, Madison; Channel 28, Menomonie-Eau Claire; Channel 31, La Crosse; and Channel 38, Green Bay.

The first hour-and-a-half program was devoted to heart disease. Coming programs are: inborn genetic defects, December 17; pulmonary disease, January 14; trauma, February 11; and cancer, March 11. Each program is aired from 7:00 to 8:30 p.m.

The series, made possible by a grant from the Bristol-Myers Company, is designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that accounted for 75.7 percent of all deaths—1½ million—in the nation last year. The WNET New York Science Program Group produced the series, which is the first of its kind, with the help of 23 medical and health professionals. Several of the stations in the state educational network are planning programs tied into the series as well as community follow-up activities.

THE NEW SUPPLEMENTAL SECURITY INCOME PROGRAM: A Prospectus for the Medical Community

HENRY A. ANDERSON, MD, Madison, Wisconsin

On January 1, 1974, a nationwide program of direct Federal payments to aged, blind, or disabled persons with limited income and resources goes into effect. Known as "Supplemental Security Income" (SSI), the new program will have uniform eligibility requirements for such persons to replace the multiplicity of requirements existing under the present Federal-State public assistance programs.

The Supplemental Security Income program will be wholly financed from Federal general tax revenues. Responsibility for administering the program has been given to the Social Security Administration (SSA) not only because of its experience in managing a monthly benefit payment program and the existing SSA advanced data processing system, but also because of the well-established nationwide network of SSA offices and program centers.

The SSI program will generally use the same definitions of disability and blindness used in the Social Security Disability Insurance program for determining eligibility in new claims. To help simplify and speed the processing of disability decisions and to insure uniform treatment of all applicants, no matter where they live, the medical evaluation criteria developed for the Title II Disability Insurance program (Social Security) with the aid of practicing physicians, medical organizations, and the Medical Advisory Committee to the Social Security Administration have been generally adopted for the SSI program. The evaluation criteria describe in terms of symptoms, signs and laboratory findings, impairments that reflect the level of severity that would prevent most people from working for a year or longer. These criteria are constantly being refined to reflect advances in medicine and to take into account disability program experience.

If an applicant has an impairment or a combination of impairments that meets or equals the criteria, and he is not working, he would generally be considered disabled. However, for workers who have impairments which fall short of the listed level of severity but which prevent them from doing their previous or customary work, consideration is given to their ability to do any other work in light of their remaining capacity and of their age, education, training and work experience.

All persons whose applications for determinations of disability are adjudicated in a State disability determination unit are considered for referral to the State vocational rehabilitation agency for consideration of rehabilitation services. The States will be fully reimbursed by the Federal Government through the Rehabilitation Services Administration for the services they provide to qualified disabled and blind SSI recipients.

With the anticipated doubling of the State disability determination unit workloads, emphasis will be placed on expanding resources within the medical community so that we will be able to get medical reports needed for adjudication of claims as quickly as possible. Although generally the same guides apply under Title II and Title XVI there are some differences. For example:

1. *No Waiting Period* — Under Title XVI (SSI), an individual who is determined to be blind or disabled will be eligible for payment for the first month in which he has filed an application and is disabled. There is no set waiting period which must be served after the onset of disability and during which payment cannot be made. (Under Title II, a 5-month waiting period must be served after the onset of disability.)

2. *Childhood Disability* — With the implementation of the SSI program, the Social Security Administration will for the first time be responsible for disability evaluation and payment for children who are under the age of 18. A child of a family with limited income and resources will be found disabled if the child has a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for at least 12 consecutive months and is of comparable severity to that which would prevent an adult from engaging in substantial gainful activity. In childhood cases, a finding of disability will be made solely on the basis of medical considerations including special medical criteria being developed for these cases within the above framework of consideration.

3. *Drug Addiction and Alcoholism* — The law provides that a disabled person, who has also been medically determined to be a drug addict or alcoholic, shall be eligible for SSI payments only if he is undergoing treatment appropriate for his condition as an addict or alcoholic at an approved institution or facility, if one is available.

Implementation of the SSI program will undoubtedly give rise to new questions and point out areas of concern with respect to the medical community and the State agencies. If physicians have any further questions or desire additional information, please contact Henry A. Anderson, MD, 310 Price Place, Madison, Wis. 53705, or telephone (608) 266-1989. □

WPS®

report

for Wisconsin Physicians

Volume 1, Number 6

November 1973

WHY WPS?

Wisconsin Physicians Service (WPS) was born of an act of the House of Delegates of the State Medical Society of Wisconsin on October 8, 1946.

A decade before the inception of WPS, the State Medical Society took the initiative to push through state legislation enabling it to establish a nonprofit plan(s) for the sickness care of indigents and low income people. This became the founding principle of WPS.

WPS in conjunction with the Society has long been a leader in the health care service field. Committees to study the need for insurance have made WPS a pioneer in providing quality health care coverage and cost control.

In 1945, one year before WPS began operations, the Wisconsin Plan offering surgical, obstetric and hospital insurance was approved by SMS. Under this program insurance reimbursements became fixed according to a prescribed fee-income schedule.

In 1948 WPS received the Seal of Acceptance under the American Medical Association's approval program.

WPS was granted use of the familiar Blue Shield symbol in the early 50's. One year into the decade WPS coverage included 216,000 Wisconsinites.

Under the direction of the newly created Commission on Prepaid Plans, the "A" and "B" schedules were adopted in 1951. These schedules specifically listed covered procedures including preoperative and postoperative care, along with corresponding insurance benefits. All new WPS business was to be written on the schedules.

All WPS activities were subordinated to the Commission on Prepaid Plans (now the Commission on Medical Care Plans).

Four years later, usual, customary and reasonable (UCR), the health insurance concept that has remained the cornerstone of WPS was first proposed. In cooperation with Blue Cross, a trial enrollment of migrant workers was undertaken. The insurance document to be used for this program became the Special Service policy.

Reimbursing physicians according to usual, custo mary and reasonable fees, a demand for payment fo service or items covered by this contract would be m if the charges did not exceed the general lev charged by others in the community for the same ser ices. Such levels were established in cooperation wit local fee advisory committees.

As WPS entered its second decade, 354,000 Wiscor sin residents came under the protection of our healt insurance plans.

In 1966 WPS began providing Medicare-PLUS co erage for senior citizens as a supplement to the fe eral Medicare legislation passed the previous year.

Late in the 1960's the concept of usual, customa and reasonable received endorsement by the Nation Association of Blue Shield Plans. Since then, partic pating Blue Shield plans have been required to mak the provision available.

In 1970 the idea of alternate forms of health care de livery and financing emerged as a possible answer t some of the nation's health care problems. The WP experimental program in Wisconsin is called HM . . . Health Maintenance Plan.

HMP is a group plan which automatically prepay physicians each month, or immediately following ser ice, for handling the health maintenance c participants.

The general objective of HMP is to provide paymer for primary care as a means of reducing hospital us and increasing preventive medicine, while continuin a dominant role by physicians in the management an control of health care delivery.

As of October 1, HMP is operational in 17 Wisconsi counties. Physician and member enrollment in thes programs is about 95 per cent.

During the past 27 years WPS has written healt care insurance for major Wisconsin businesses. W have also issued contracts for 300 municipalities, util ties, professional associations and hospitals acros the state.

For over a quarter century WPS has meant peopl caring for people.

and their Medical Assistants

Reminders on HMP

Referral System (Applies to HMP in Green, Richland, Pierce-St. Croix, Dodge, Langlade, Lincoln, Clark and Sauk counties).

In the course of an examination a physician may find t necessary to refer his patient to another doctor for special treatment. In the case of an HMP participant this means that specific steps must be taken.

Under HMP, when a primary physician feels that special attention is needed for his patient, referral to another physician may be made with the proper authorization.

A copy of a referral authorization (IBM card or long form) must be sent to WPS HMP. This will alert the claims adjusters to the action.

If a claim is received from a physician other than the primary and there is no referral authorization on file, a letter will be sent to the HMP participant. A copy of this letter will also be sent to the primary's office.

Should you receive such a request for referral information please find out immediately if the primary physician concerned made a referral. We follow this procedure to allow the patient the benefit of the doubt.

Failure on the part of the physician or the patient to respond to the letter within 30 days will result in the HMP participant being removed from the program. He or she will revert back to regular WPS benefits.

HMP Identification

All medical records and charts for HMP patients must be stamped "HMP." WPS will provide the rubber stamps needed. If you need a stamp, write us immediately.

The Health Maintenance Plan is a relatively new health care delivery and financing system. It is, of course, just in the experimental stage. We at WPS appreciate anything you can do to help make HMP work. We understand that there are minor problems inherent in such an undertaking. If you need any additional information or explanation, please contact the HMP department in Madison.

NEW BOOKLET AND FILM IN

Suicide
The Will to Die

" 'Suicide is first, foremost, and last, a highly personal, highly individual affair. It is, from many points of view, the most tragic expression of human despair.' " Joseph Hirsh, Ed.D., of the Temple University School of Medicine, expresses the opinion that suicide threats, attempts and deaths are often a cry for help and not an actual desire to die. The true facts about suicide don't lie in statistics, but with the personal hell that touches the lives of perhaps nearly 60,000 Americans a year. Much needs to be learned about suicide and its victims. This booklet deals with the causes, warnings and preventions of this major community health problem.

For copies of booklet and/or film write:

WPS Advertising Department
Box 1109, 330 East Lakeside St.
Madison, Wisconsin 53701

WPS
WISCONSIN PHYSICIANS SERVICE

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions Dimetapp is not recommended in the treatment of bronchial asthma. Also Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

COUNCIL MINUTES

State Medical Society of Wisconsin—Madison, July 14-15, 1973

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m. on Saturday, July 14, 1973, at the State Medical Society.

Voting members present: Doctors J. J. Foley, Olsman, Nordby, Edwards, McKenzie, Rohde, Heinen, Lewis, Manz, Doyle, Inda, Schmidt, Williams, President Derus, Past President Purtell, Speaker Hamlin. Present Saturday only: Doctors Beilman, Mauthe, LaBissoniere, T. J. Foley, Pittelkow, Meyer.

Others present part or all of meeting: President-elect Dettmann; Vice-Speaker Stuff; Doctors Picard, Russell, Kief, Paul Mason, Owen Miller, Headlee, Handy, Holmes, Biek; Messrs. Thayer, Maroney, Koenig, Doran, Brower, Johnson, LaBissoniere, Brown, Brodersen, McIntyre, Murphy, Kluwin, Gill, Vaughan, Lien; Mmes. Johnston, Scott, Davenport, Anderson; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Edwards-Heinen, carried, the Council affirmed its mail ballot approval of minutes of the May 10, 1973, special meeting with an amendment that the State Medical Society of Wisconsin rather than the Secretary be named as incorporator of Wisconsin Physicians Service Insurance Corporation.

3. Request of Nursing Home Ombudsman Office

The Council had received copies of an exchange of correspondence between Lieutenant Governor Schreiber and the Secretary in which the former as nursing home ombudsman alleged inadequate care of nursing home patients, with particular reference to physical examinations. The Lieutenant Governor had not yet responded to requests for specific details from which to evaluate the nature of problems or complaints.

On motion of Doctor Manz, seconded and carried, the Council approved the recommendation of the Executive Committee that the Committee on Peer Review and the Division on Aging be asked to look at any cases he does submit, and in any event to study the current legal requirements in various types of facilities for ultimate publication as guidelines for physicians on nursing home care, since these do change in reference to Medicare and Medicaid.

4. Proposal for Joint Bio-Equivalency Review Committee

The Wisconsin Pharmaceutical Association had expressed an interest in the creation of a joint committee of physicians and pharmacists to study the feasibility of establishing a formulary of drugs which might be regarded as chemically or therapeutically equivalent. Several current legislative proposals go beyond this and suggest the creation of a drug quality review board. The official position of the Society taken on a similar proposal in 1971 is that a study should first be conducted of generic name prescribing and dispensing to determine whether and to what extent therapeutic equivalency actually exists, potential cost savings to purchasers that might be anticipated, and the cost of implementing and enforcing such a program.

On motion of Doctors Lewis-Hamlin, carried, the Council approved the recommendation of the Executive Committee that such a joint committee be created and accepted its nominations of physician members to represent the Society, suggesting the addition of a member from each medical or pharmacy school.

5. Ethical Guidelines for Hospital and Medical Public Relations Activities

Several officers and councilors of the Society have expressed concern about the "public relations" activities of medical clinics and hospitals. A preliminary staff-level discussion of these problems had been held with staff of the AMA, the Wisconsin Hospital Association, University Hospitals, a medical clinic, and the Medical Society of Milwaukee County.

The Executive Committee reviewed some of the monthly or quarterly publications of both clinics and hospitals which at least in the manner of their widespread distribution would appear to constitute outright solicitation of patients. It believed that ultimately appropriate representatives of the Hospital Association should be joined in a determination of ethical guidelines, but recommended first that several officers or councilors meet with the Department of Medical Ethics of the AMA to formulate a consensus on the ethics of the entire matter as a concern of medicine.

On motion of Doctor Olsman, seconded and carried, this recommendation was approved.

6. Separate Incorporaton of WPS

The Executive Committee reported discussion by the Secretary of views that have been expressed as to the intent and meaning of action by the House and Council in March authorizing an application for incorporation of WPS as a stock insurance company, and subsequent actions of the Council in May, as to the future relationships between the Society and WPS. Some believe that WPS is or will be totally independent and it was felt that a further declaration of policy was needed to clarify the intent. The committee presented two resolutions for action by the Council, which assume favorable action on the application by the Insurance Commissioner, one having to do with policy and administrative relationships, and the other relating to adoption of articles and bylaws of Wisconsin Physicians Service Insurance Corporation.

On motion of Doctors Rohde-Edwards, carried, the following resolution was adopted:

"WHEREAS, The transfer of the insurance operation of the Society from its WPS division to a separately incorporated, wholly-owned subsidiary, called 'Wisconsin Physicians Service Insurance Corporation,' has received preliminary approval by this Council consistent with House of Delegates action in March 1973; and

"(a) Steps have been taken to create this new corporate subsidiary and obtain for it the necessary legal authorization to operate an insurance business in Wisconsin; and

"(b) The new structure through which the Society will conduct its insurance operations will require certain adjustments in its internal organization; and

"(c) This new subsidiary must be fitted into an overall structure including the Society, its divisions, functions and existing subsidiary corporations;

"*Resolved*, That:

"1. The State Medical Society of Wisconsin, as sole shareholder of Wisconsin Physicians Service Insurance Corporation, maintain that degree of active policy control over the Insurance Corporation which will assure its responsiveness to the profession it represents and the public it serves;

"2. The Insurance Corporation keep the Society fully advised of its operations and make its recommendations for policy positions and changes to the Council of the Society for its approval; and, consistent with the procedure applicable to all Society divisions, functions and subsidiaries, such reports and recommendations shall be forwarded to the Council through the Society's Secretary and General Manager;

"3. The technical and administrative relations of the Society to all its divisions, functions and subsidiaries remain the responsibility of the Society's Secretary and General Manager;

"4. There be a continuing identification of Wisconsin Physicians Service Insurance Corporation with and as a part of the State Medical Society of Wisconsin."

On motion of Doctors Olsman-Doyle, carried, the following resolution was adopted:

"Resolved, That:

"1. The proposed Bylaws of Wisconsin Physicians Service Insurance Corporation be and are approved and adopted; provided that the President, Chairman of the Council, and Secretary are authorized, on behalf of the Society as sole shareholder of the Insurance Corporation, to meet and adopt Bylaws, should that be necessary following the issuance of a certificate of incorporation for the Insurance Corporation; provided further that should any amendments to the proposed Bylaws be recommended or required by the Commissioner of Insurance, such amendments shall be submitted to the Council for approval;

"2. The President and Secretary are empowered to execute and file the Articles of Incorporation of Wisconsin Physicians Service Insurance Corporation following approval of the pending application by the Commissioner of Insurance and the negotiation by the President, Chairman of the Council and Secretary of an agreement for the transfer of certain of the Society's assets to the subsidiary Insurance Corporation, all of such actions to be consistent with the Insurance Corporation's Articles and Bylaws and the actions and policies of the Council and the House of Delegates of the Society."

Prior to adoption of the above resolution, copies of the proposed articles, bylaws, and agreement on transfer of assets were distributed and reviewed with Council members.

Doctor Dettmann stated for the record his understanding that everything that has transpired thus far in relation to WPS is in accord with National Blue Shield policy and in no way negates the use of the Blue Shield name and symbol.

7. Further Report of Executive Committee

A. OEO-HEW Grant to University of Wisconsin for Research on Improving the Health Status of the Poor

The committee advised the Council of a research project to be carried out in two "target areas" of selected northern Wisconsin counties, one in which to test the effect of improved delivery of health care services and the other to test the effect of improved environment on health status of the poor. The Society, having been informed of the research grant, was not asked for any endorsement or involvement. It is planned to provide councilors in the areas of the project with such information as is available.

B. Wisconsin Regional Medical Program

The Society had been asked for an expression of its views to the board of WRMP as to several alternative future courses when federal funding ceases. It appeared that the State Health Policy Council was interested in taking it over as a research and development body, which the Executive Committee did not favor as WRMP would lose its identity.

After discussion of the alternatives and whether the Society should state a position, on motion of Doctors Lewis-Edwards, carried, the Council went on record as favoring its continuation as an independent agency if it remains in existence.

8. WHCRI and PSRO

The Council had received a copy of the recently announced hearing to be held on July 31 to commence the process of PSRO area designations by HEW. A presentation was made to the Council in support of a statewide area designation for Wisconsin with Wisconsin Health Care Review, Inc. as the coordinating agency which would contract for actual review with local units. Mr. McIntyre reviewed a series of actions by the Council and House of Delegates beginning in 1970 which led to the organization of WHCRI and the official position that Wisconsin should seek a statewide quality assurance program coordinated by WHCRI. He also discussed implementing activities and discussions of a relationship with the Foundation for Medical Care Evaluation of Southeastern Wisconsin organized by the Medical Society of Milwaukee County in 1973.

Paul Mason, MD, President of WHCRI, and Owen Miller, MD, chairman of the Society's Committee on Peer Review, discussed the importance of the PSRO law and the dangers of allowing fragmentation of the state in dealing with the government. Both urged that WHCRI be given at least a year to demonstrate what can be done. Mr. Thayer said there was every reason to believe that HEW would not insist on more than one PSRO in a state, as has been suggested, if there is unanimity of support for a statewide option.

On motion of Doctors Beilman-Doyle, carried the Council reiterated its support of the statewide area concept with WHCRI as the coordinating organization.

Milwaukee councilors were asked their opinion as to what position the Milwaukee-based foundation would take on July 31. This led to another motion of Doctors Derus-TJFoley, carried, that the Executive Committee seek a meeting with officers of the Milwaukee foundation to attempt to arrive at a uniform presentation for the meeting with the federal government on July 31; such meeting to include Doctor Mason of WHCRI and Doctor Miller of the Committee on Peer Review.

Doctor Derus was asked to arrange the meeting, and it was agreed the Milwaukee councilors should also be invited.

9. Report of AMA Delegates

Doctors Picard, Kief, and Russell reported informationally on the recent AMA convention.

10. Legislation

Mr. Ed Lien, who will join the Society staff on August 1 as director of governmental affairs, was introduced, as was Michael Vaughan of the law firm of general counsel Murphy, who is acting as one of the Society's legislative representatives.

A. Health Services Commission (AB 489)

Mr. Vaughan informed the Council of the status of AB 489 which had been tabled but was not dead, and also discussed the possibilities of an acceptable separate certificate of need bill being passed in this session.

B. Proposed Repeal of Basic Sciences Act

The Council received copy of a letter from Basic Science Board Secretary Kettelkamp who urged that if the Act is to be repealed and the Board abolished, some provision be made to ensure adequate and equal testing in the basic sciences of every individual seeking licensure in any of the healing arts. The Society's Ad Hoc Committee on Chiropractic felt that repeal should be seriously considered in all its implications.

On motion of Doctors Williams-Olsman, carried, this committee was asked to give it further study and report back to the Council in November.

C. Proposed Treatment of Minors Bill

Mr. Maroney discussed the proposed text of a bill which would waive parental consent for treatment of minors virtually without limits. It was pointed out that the physician who was seeking introduction of the bill had also submitted it to the Dane County Medical Society for recommendations on correcting or improving the proposal.

On motion of Doctors Olsman-Edwards, carried, the Council referred it to the Commission on Public Policy to recommend improvements.

D. Status Report on Other Legislation

Council members received for information a report on the status of 82 "action" bills of particular interest to medicine.

11. Thomas J. Doran

Doctor Nordby announced with reluctance that Mr. Doran had decided to retire on July 31. On motion of Doctors Mauthe-Doyle, carried, the Council expressed its appreciation for his years of service with the Society.

The Council recessed at 5:25 and reconvened at 9:30 a.m. on Sunday, July 15.

12. Report of Committee on Economic Medicine

Doctor Schmidt reported proposals of the committee for repromoting the existing disability insurance program for members and also offering special programs for residents and for employees of members.

He noted that in the recent revision of the travel accident insurance program, benefits had inadvertently been decreased for certain Society employees and the committee has requested correction of this situation.

The committee had again discussed the advisability of seeking a group professional liability program for the membership and concluded there was no need for it at the present time.

The committee had been asked to advise the Secretary with reference to a report of the HEW Commission on Medical Malpractice since he is a member of a State Health Policy Council committee which is to study this report and make recommendations on whether the State should undertake implementation of certain of its recommendations. The Wisconsin Legislature has also directed a study of professional liability problems in the state by the Legislative Council. Doctor Schmidt reported that a report of the AMA board of trustees which was a summary and analysis of the HEW Commission report was discussed by the committee with Mr. Thayer as the basis of its advice to him.

Doctor Schmidt asked for Council approval of the proposal for offering a disability insurance program designed especially for employees of Society members since this has not previously been reported to the Council. This was approved on motion of Doctors Schmidt-Purtell, carried.

On motion of Doctors Edwards-Doyle, carried, the committee report was approved as a whole.

13. Report of Planning Committee

A. Planning Committee Hearings

Doctor Manz reported that the open hearings held by the committee during the annual meeting had been poorly attended, and while they did provide a forum for members, the committee did not recommend that this be continued in 1974.

B. Committee Structure

The committee has begun a complete review of the Society's committee structure. The chairman reported that it is seriously considering the termination of the Commission on State Departments as a separate entity as it is believed that either the Planning or Executive Committee can adequately coordinate the work of its ten divisions, thus eliminating an unnecessary procedural step.

On motion of Doctors Purtell-Doyle, carried, the Council acted to terminate the Commission on State Departments with thanks, preserving the divisions within it with direct reporting to the Council.

Doctor Manz reported a further recommendation that the Council give consideration to the creation of a Committee on Health Care Delivery Systems with the responsibility of reviewing the various proposals for new types of health care delivery systems being proposed and implemented.

Doctor Nordby suggested that action on this recommendation would be appropriate at such time as the Commission on Medical Care Plans should become the board of directors of the WPS insurance corporation. It was generally agreed that this should be laid over.

The committee also suggested that the Chairman of the Council be authorized to appoint an ad hoc committee to consider proposals of the State Health Policy Council, the successor to the Governor's Health Planning and Policy Task Force of which the Secretary is a member.

Mr. Thayer explained that the area into which this Council is moving is broad and involved and he felt it would be well to have a designated body in the Society from which to secure medical reaction on a continuing basis.

After discussion, it was agreed on motion of Doctors Edwards-Doyle, carried, that rather than creating a new committee the Secretary should continue to consult with officers and the Executive Committee on matters coming before the Health Policy Council.

C. Non-medical (surgical) assistants

At the request of the Commission on Medical Care Plans, the Planning Committee was asked to recommend guidelines for the reimbursement of non-medical surgical assistants. The committee suggested that an AMA position of 1972 be adopted by the Council as its policy.

Wide ranging discussion ensued, and on motion of Doctors Schmidt-Purtell, carried, the entire matter was referred to the Executive Committee for further study and report in November, with an expression that there is objection in principle to the concept of establishing separate fee schedules for non-medical assistants.

D. Ombudsman

Doctor Derus had proposed in his inaugural address that the Society create an ombudsman service to handle complaints and other problems presented by patients. It was recognized that many county medical societies have active and effective grievance committees to function in this capacity, as does the State Medical Society. It was agreed that county societies be encouraged to give further publicity to the availability of this patient service.

E. Reimbursement of Society Officers

The Planning Committee recommended that the Council give consideration to increasing the current reimbursement of the President and President-elect for the ever increasing work load being demanded of these offices, and suggested that it be referred to the Finance Committee for study of the fiscal impact.

Doctor Purtell requested that this be discussed in an executive session at the conclusion of the meeting.

14. Report of Finance Committee

Doctor Edwards reported that the committee had reviewed general fund expenses in relation to the budget and had some preliminary discussion on a 1974 budget. Specific mention was made of the following:

A. In response to a recommendation from the AMA, the committee proposed authorizing an expenditure up to $1500 in future budgets to finance attendance of residents at AMA meetings, but only on evidence of sufficient interest in the affairs of organized medicine.

B. The committee approved the recommendation of the Secretary that general insurance coverage of the Society, its divisions and affiliates, be reviewed by an outside consulting firm in view of the present multiplicity of policies.

C. The committee discussed a request from WISPAC for an administrative fund appropriation from the Society dues, and recommended that consideration of this be postponed pending results of another year's promotion and billing of WISPAC membership dues.

D. The committee recommended that dividends on employee life insurance programs be applied to reduce the employer portion of the next year's premium, thereby crediting the entity originally incurring the expense; this to be done so long as the dividend does not exceed the total employer portion of the premium.

E. The committee received a progress report from a special committee of the Commission on Medical Care Plans which is studying cost allocations between the Society and WPS.

F. The committee approved salary adjustments in the range within its authority; reported that the charges for Attorney Tinkham's attendance at the annual meeting had been paid from the general fund; that Mr. Ragatz had begun part-time work as a special assistant in postgraduate education coordination; and that an agreement with the First Wisconsin National Bank to act as investment counsel on the employee pension plan had been approved.

On motion of Doctors JJFoley-McKenzie, carried, the committee report was approved as a whole.

15. Space Utilization and Future Planning at 330 East Lakeside and Associated Properties

It was reported that the SMS Realty trustees had approved a six months' extension on the option to purchase

the Easter Seal-Marsden property to provide prospective developers more time to secure zoning changes; also that they had approved purchase of another piece of rental property in the neighborhood.

There was also discussion of the property on Broadway where a building is being constructed for lease by WPS. In approving execution of a lease-purchase option in March, authority was for lease only and that location was considered a temporary one, not a potential for Society headquarters, pending an ultimate decision on consolidation of the Society and all divisions or subsidiaries at one site, whether on East Lakeside or elsewhere. Any proposal to purchase Broadway property would come before the Realty Corporation. It was also agreed that there would be a five year lease by WPS of space now occupied in the present Society headquarters to assure financial stability in light of current commitments to 330 East Lakeside. As mentioned earlier, a special committee on the Commission on Medical Care Plans is analyzing the methods of determining cost allocations for jointly shared services between WPS and other Society operations as well as cost of space.

At its recent meeting the trustees had authorized a study of cost and other factors in ultimately consolidating all operations on East Lakeside property prior to entertaining any decision that it is too expensive, as has been suggested.

16. Report of Commission on Medical Care Plans

The Council received the following report from the Commission:

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS TO THE COUNCIL—JULY 1973

The first five months of 1973 have produced excellent operating results. $1,500,000 was added to general reserves after satisfaction of claim liabilities and administrative expenses. Eighteen thousand additional people are now covered by WPS, bringing the total number of people covered to over 524,000.

NABSP groups Member Plans by membership size for the purpose of comparative reporting. WPS data is reported as one of eighteen Plans covering between 200,000 and 500,000 persons. While there are substantial variations in circumstances from Plan to Plan, comparisons are an objective method of measuring performance. At the end of 1972, WPS had the largest premium income and the second largest membership count in this grouping. Of this 18-Plan grouping, only six Plans used a smaller percentage of premium income for operating expenses. During this same period, WPS experienced a larger gain in the number of persons covered than all but two of these eighteen Plans. These comparisons suggest that, in relation to other Plans, WPS has enjoyed a very favorable year during 1972.

Green, Pierce-St. Croix, Richland, Dane, Sauk and Clark Counties have active HMP programs with about 660 physicians providing care for 19,400 enrolled members. Jefferson, Lincoln, Langlade, Price-Taylor and Dodge Counties have agreed to implement HMP programs. In these counties, 78 physicians out of 83 have agreed to participate, with Dodge County physician enrollment incomplete. Members for these programs are pending enrollment. HMP members currently involve nearly $3,000,000 of annual premium—about 5 per cent of the WPS total. Encouraging, but inconclusive data shows apparent reductions in hospital days used, while total claims expenses seem to be within a tolerable range.

If the HMP idea is to influence thinking on the national scene, it must become widely known and well accepted. Until recently, many equated "HMO" with "Closed Panel." Through publicity efforts, WPS hopes that the HMP idea will be accepted as an "Individual Practice HMO." To this end, favorable releases are being obtained in *Medical Economics, Employee Benefit Plan Review* and *The Blue Shield*. WPS sponsored a national HMP meeting for Blue Plans early in June, which was attended by 100 interested persons representing about forty Plans.

The Commission approved the development of a Health Services Review program for the review of the utilization and cost control of health care services. Review of submitted claims and screening of provider practice patterns against peer profiles are accomplished under a medical advisor's direction so as to evaluate the reasonableness or medical necessity of rendered services. Exceptions are referred to the SMS Committee on Peer Review (through WHCRI) for final review and evaluation, with the ultimate objective of promoting the appropriate utilization of professional and institutional health care services by the public.

As an initial step toward mechanization of claims reporting and statistical data collection between physicians' offices and WPS, the Commission's Executive Committee authorized the provision of accounts receivable, monthly billing, and claim form preparation services to physicians. These services are now provided to one Madison clinic and will soon be implemented at a second location. Further interest has been generated in other clinics throughout Wisconsin. The services are provided at current costs for machine and personnel time and cost of required supplies.

Most of the attention at the NABSP Annual Business Meeting was directed toward proposed changes in Bylaws and Membership Standards. Changes to Bylaws must be laid over for one year, so none were enacted—although it was proposed to eliminate this requirement and instead require only sixty days' notice of proposed Bylaw changes to the Member Plans. One of the most significant proposals was to change the name to "Blue Shield Association." This, and the sixty-day notice for Bylaw changes, were approved but cannot be effective until they are approved again at next year's annual meeting. A much more controversial matter was the proposal for reorganizing the Board of Directors. As might be expected, the special interests involved in Small vs. Large Plans and the advocates of increased representation by Physician Directors, Plan Executive Directors, and Public Directors were all heard from at length. Five proposals for Board reorganization were laid over for consideration next year.

Changes in Membership Standards were enacted, making it "preferable" instead of required that paid-in-full programs be based upon Usual, Customary and Reasonable charges. Other changes require submission of a Utilization Review and Control Program by each Plan, which is subject to evaluation on NABSP Board-established criteria. Previously arbitrary reserve requirements for Plans were replaced with the requirement that reserves be "adequate,"* and that Plans in financial trouble report to the NABSP Board. Participation in the Blue Shield Index (a sort of NABSP Relative Value System) was added as a requirement.

*A fine report from the Actuarial Committee was discussed and approved in principle, but not incorporated into the Membership Standards. Many Plans expressed concern that specific "standards" would be interpreted as maximum permissible reserves by their regulatory authorities. "Adequate" was loosely defined as three months of claims and expenses, while "in trouble" is less than 1½ months. WPS presently operates on reserves equivalent to approximately 2½ months of claims and expenses.

The phrase "may be" was substituted for "shall be" in the following condition of membership, which now reads:

> A Plan shall have the substantial support of the Medical Profession, evidence of which *may be* the approval of the Plan by the appropriate Medical Society.

In addition, it is now further stated that:

> The NABSP Board shall determine the adequacy of the support.

In the fall of 1972, WPS quoted a large labor trust on benefit specifications written by the buyer, including benefits for vision care with specifications which conformed precisely to the benefits written by Wisconsin Vision Services, Inc. These specifications called for a Usual, Customary and Reasonable benefit for optometrists, but an indemnity schedule for ophthalmologists. WPS instead quoted an alternative which provided UCR benefits for both. This alternative was accepted by about one-fifth of the group, and WPS now has about 1,300 contracts in force on this basis. Approximately two-fifths of the group selected the benefit structure offered by Wisconsin Vision Services, and as a result they have between 6,000 and 7,000 contracts presently in force with this group.

Today's economy and tight money situation has produced an overly price-conscious market place. The possibility of a National Health Insurance Program has ap-

parently prompted the commercial insurance companies to attempt to increase their share of the health insurance market, even at the risk of lowering rates to the point where it is unprofitable. Employers' contributions to group health premiums have increased and in many cases are now 100 per cent, which in effect takes the buying decision away from the employees and contributes further to price rather than service being the deciding factor. Even in light of all these adverse conditions, WPS—still operating with its heavy emphasis on service rather than price—has more than maintained its competitive position in the market place.

The initial filing of separate incorporation papers for WPS with the State Insurance Department was recently accomplished, consistent with the SMS House of Delegates resolution based on the recommendation of the Council. It is expected that the initial review by the Insurance Department could take thirty days or more, and at that time we would receive the first indication of the total time and complexity factors necessary to achieve separate incorporation.

The Milwaukee Regional Claims Office, established late in 1972 to meet the requirements of a new large group of subscribers, is now paying an average of 1,000 dental and vision benefit claims per month. All of these claims are paid within five days of receipt. Consideration is being given to expanding this regional concept and including payments for all benefits.

WPS's 1972 television advertising program was awarded the second place 1972 National Addy Award by the American Advertising Federation in a competition with all the television advertising in the country. The quality of this advertising has allowed its being used for more than one season. Production is presently underway to develop another top quality TV advertising program to phase into and eventually replace the present advertising during the next television season.

The CMCP Executive Committee undertook increased review of current WPS investments. Written communications from investment counsel concerning all buy and sell actions are distributed and quarterly meetings are held with them. As recommended by investment counsel, the allowed portion of the total portfolio which may be invested in stocks was increased. A more progressive investment policy was adopted, which points toward increased holdings of stocks and increased investments in the growth area.

The following chart presents statistics for some of the many WPS performance indicators for the last ten years: (chart appears at bottom of page)

1. It should be noted that the excellent steady premium income growth was significantly less in 1971 due to the loss of the State Employees Group in the third quarter of 1970.
2. Also worthy of note is the excellent downward trend of Administrative Expense as a percentage of premium from 11.9% in 1963 to 7.7% in 1972.
3. The losses in Number of Contracts in 1969 due to competitive "rate cutting" and in 1970 due to the loss of the State Group have been more than recovered by May of 1973.
4. Since the addition of Miscellaneous Illness Expense, Dental and Vision contracts to the WPS benefit portfolio, the number of contracts designated as "Other" (which also includes the Drug Benefit) has risen to almost 33,000 from the 600-1,800 range for the years 1963-1969.

These represent the more important matters that should be of interest with which the Commission has been involved since its last report to the Council.

Respectfully submitted,
/s/ E. M. Dessloch, MD, *Chairman*
Commission on Medical Care Plans

Mr. Koenig said that the Commission had discussed inclusion of chiropractic benefits under Medicare at its meeting a week ago and as a Part B carrier, WPS intended to question the definition of chiropractic services to be reimbursed, secure clarification on X-ray demonstration of subluxations, and the like so as to be better able to properly carry out its responsibility for administration of this new and untested benefit area of Medicare.

	PREMIUM INCOME	INVESTMENT INCOME	TOTAL INCOME	INCURRED CLAIMS	ADMINISTRATIVE EXPENSE (% PREMIUM)	TOTAL EXPENSE	TOTAL RESERVES	NUMBER OF CONTRACTS			
								SURGICAL MEDICAL	HOSPITAL	MAJOR MEDICAL	OTHER
1972	$50,729,000	$871,000	$51,600,000	$43,937,000	7.7% 2.	$48,527,000	$11,063,000	188,156	153,972	134,470	32,943 4.
1971	$44,507,500 1.	$1,034,200	$45,541,700	$39,736,500	8.8%	$44,078,000	$7,191,700	163,182 3.	131,205	108,986	23,479
1970	$41,446,800	$814,800	$42,281,600	$37,367,000	9.1%	$41,530,400	$5,720,500	212,029	133,792	145,986	11,655
1969	$34,883,700	$707,300	$35,591,000	$31,763,400	9.5%	$35,102,500	$5,304,700	214,668 3.	132,576	129,714	1,710
1968	$28,179,500	$421,000	$28,600,500	$25,969,500	10.3%	$28,879,200	$5,212,000	228,338	153,363	130,603	600
1967	$22,866,100	$494,600	$23,360,700	$19,670,500	11.1%	$22,246,800	$5,632,700	182,797	111,049	100,476	750
1966	$19,260,600	$347,000	$19,607,600	$16,684,000	11.6%	$18,653,400	$4,349,400	160,609	92,391	80,615	1,060
1965	$17,696,600	$257,000	$17,953,600	$15,502,800	10.2%	$17,252,300	$3,221,600	141,879	69,162	45,114	1,679
1964	$15,358,500	$220,000	$15,578,500	$13,796,000	11.5%	$15,505,800	$3,437,900	135,944	67,296	36,415	1,775
1963	$13,238,900	$186,300	$13,425,200	$11,469,500	11.9%	$12,982,700	$2,873,800	130,080	58,151	28,286	1,828 4.

17. Appointments

A. AMA Councils and Committees

Members of the Council nominated seven Wisconsin physicians for membership on AMA Councils and Committees on which vacancies will occur at the end of 1973.

B. Editorial Board

A physician and an alternate were nominated for contact as to acceptance of membership on the Editorial Board of the *Wisconsin Medical Journal.*

C. Committee on Peer Review

Erwin O. Hirsch, MD, was elected to this committee representing the Medical College of Wisconsin.

D. Nursing Home Administrators Examining Board

The term of Nels A. Hill, MD is expiring and he does not wish reappointment. Council members suggested several nominees to be submitted to the Governor for consideration.

18. Informational Reports

Reports were provided the Council for information on activities of the Blue Cross rate review program and on the number of physicians residing and practicing in Wisconsin in relation to the number of members of the Society.

19. Miscellaneous

The Council agreed to cosponsorship with the Wisconsin Hospital Association of a conference for trustees, administrators and physicians on September 21-23; suggested that the Nominating Committee be asked to meet the morning of Saturday, November 3, the date of the next Council meeting; and changed the dates of the next succeeding meeting to February 2-3.

20. Physician Reprimand

The chairman referred to newspaper accounts of a decision by the Medical Examining Board to issue a public reprimand of Henry M. Suckle, MD, which then was withheld from the public until reporters learned of it. The executive secretary of the Board had not released it because "we don't promote trouble in our profession." Consensus of the discussion was that this action was a disservice to the profession and the public which should not be shielded from such an action.

On motion of Doctors Lewis-Doyle, carried, the Council directed that a letter be sent to the Medical Examining Board expressing disapproval of the manner in which it handled the "public reprimand" in reference to Doctor Suckle, such communication to be made public.

21. Executive Session

22. Adjournment—12:15 p.m.

EARL R. THAYER
Secretary

Approved: Nov. 3, 1973
EUGENE J. NORDBY, MD
Chairman

□

SECTION OPHTHALMOLOGY

NOVEMBER 1973

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

NEW EDITOR FOR OPHTHALMOLOGY PAGE

Dr. Thomas M. Aaberg of the Medical College of Wisconsin in Milwaukee has consented to be editor of the ophthalmology page. Doctor Aaberg, being in Milwaukee in the center of the greatest concentration of ophthalmologists in the state, will be able to provide a means of communication to other ophthalmologists in the state.

I think after five years as editor someone else should have the opportunity to present new ideas and views on the business of the Section on Ophthalmology of the State Medical Society of Wisconsin.

—JAMES C. ALLEN, MD

RHODE ISLAND BATTLE

The Rhode Island Ophthalmological Society has begun a new case in the federal courts in Rhode Island to stop optometrists from using topical-administered drugs. The Society also has appealed a lower state court ruling to the Rhode Island Supreme Court. The Rhode Island Ophthalmological Society has 27 members and has spent $25,000 on legal fees the last two years. They are requesting financial support to continue the fight.

OPTOMETRY SCHOOL PROPOSAL

After a vigorous and active legislative fight by the ophthalmologists of Florida, efforts by the optometrists to establish a school of optometry in Florida were defeated in the 1973 Legislature. This was accomplished against all the odds by the extensive personal contacts by the ophthalmologists to their local senators and representatives.

DOOR COUNTY HAS OPHTHALMOLOGIST

Dr. Aubrey A. Drescher has moved from Menomonie, Wisconsin, and has opened an office for the practice of ophthalmology in Sister Bay, Wisconsin.

WISCONSIN SOCIETY FOR PREVENTION OF BLINDNESS AIDED

The Davis-Duehr Clinic, located near Camp Randall Stadium on the University of Wisconsin-Madison Campus, rents its parking spaces during football games, with the receipts donated to the Wisconsin Society for the Prevention of Blindness. □

The patient with asthma or allergy: another type for Tylenol (acetaminophen)

When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,[3] making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961: abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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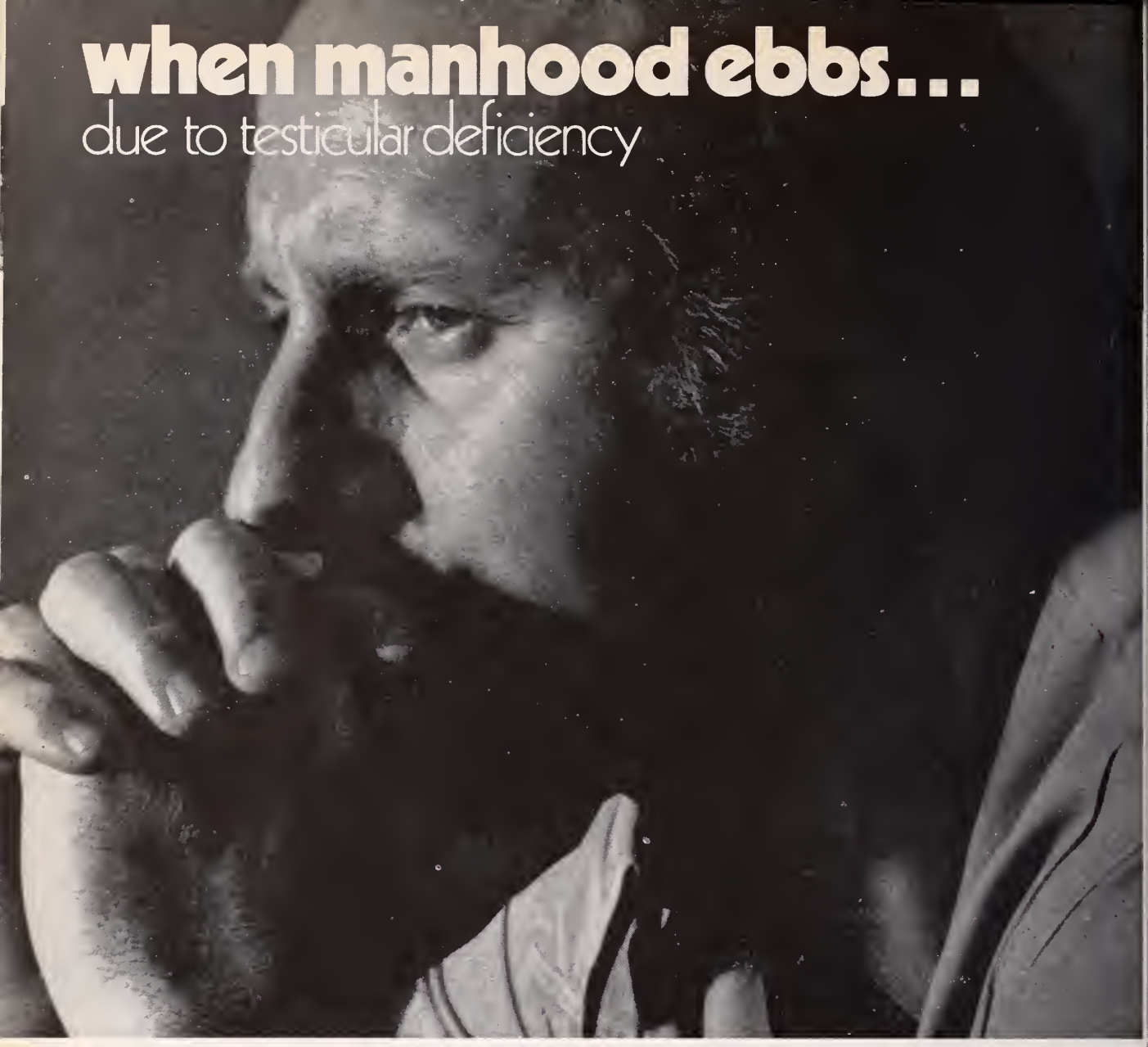

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Same effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13 Beeson, P. B. and McDermott, W. eds. Philadelphia W. B. Saunders Co., 1971, p. 1B16.

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NEWS HIGHLIGHTS

Max Fox Preceptorship Awards Given

A Rhinelander physician, Warner S. Bump, MD,* and a Wauwatosa physician, Einar R. Daniels, MD,* were honored by the University of Wisconsin Medical School and its alumni association for their long service to medical education. Doctor Bump was presented the Max Fox Preceptorship Award in ceremonies held during the Oneida-Vilas County Medical Society meeting September 26. Doctor Daniels received a similar award in ceremonies at Lutheran Hospital of Milwaukee's medical staff meeting September 20. They were the fifth and sixth persons to receive the award which is sponsored by the medical alumni association and honors physicians for their efforts in developing medical preceptorship in Wisconsin. The honor is named after Dr. Max Fox, a Milwaukee physician who was an early preceptor.

Doctor Bump, seated, surrounded by distinguished colleagues, left to right, William S. Middleton, MD,* Madison, emeritus dean of UW Medical School; Marvin Wright, MD,* Doctor Bump's first Rhinelander associate; Frank L. Weston, MD,* Madison, a '23 classmate; George P. Nichols, MD,* Appleton, class of '48 and his first preceptee; and Thomas Haug, MD,* class of '47 and current Rhinelander preceptor who helped make the arrangements for Doctor Bump's presentation of the Max Fox Preceptorship Award.

The program, pioneered in Wisconsin over 45 years ago, allows senior medical students at Madison to spend eight weeks with a practicing physician and helps to shape their medical careers. Students accompany the local doctor on his hospital calls, observe his hospital and office practice, and help the physician in some duties.

Doctor Bump was oldest in terms of service when he retired as head preceptor in Rhinelander last year. During his 26 years over 150 UW medical seniors learned small town medical practice firsthand from Doctor Bump and his associates. Doctor Daniels served as a preceptor for senior medical students from 1958-1965.

UW-Madison Vice Chancellor for Health Sciences Robert E. Cooke, MD and Emeritus Medical School Dean William S. Middleton, MD* led a Madison delegation to both ceremonies.

Wisconsin Society of Pathologists Elects Officers

The annual meeting of the Wisconsin Society of Pathologists, Inc. was held in Green Bay October 6 with the following officers elected to their respective terms of office: president, Marvin D. Blackburn, Jr., MD,* Green Bay; vice-president, Dean M. Connors, MD, Madison; secretary and councilor to ASCP, Roland C. Brown, MD,* Milwaukee; treasurer and alternate councilor to ASCP, Donald J. Stevenson, MD,* Madison; board of censors, David J. LaFond, MD,* Milwaukee, and Paul R. Glunz, MD,* Beaver Dam; delegate to State Medical Society, Robert E. Carlovsky, MD,* Fond du Lac; and senior delegate to CAP, Herman J. Dick, MD,* Sheboygan.

Wisconsin Society of Therapeutic Radiologists Elects

New officers recently elected to serve two-year terms in the Wisconsin Society of Therapeutic Radiologists include Robert Greenlaw, MD,* Marshfield, president; Robert Edland, MD,* La Crosse, vice-president

PHYSICIAN BRIEFS

John H. Renner, MD*

. . . has been appointed acting chairman of the Family Medicine and Practice department at the University of Wisconsin-Madison Medical School. Since 1970 Doctor Renner has been director of the program which preceded the new department that was created by the UW System Regents in October. The Family and Medical Practice department currently has 24 resident physicians in training and operates clinics that serve patients from facilities at St. Marys Hospital Medical Center, Verona, and Madison's northeast side. The new department has a faculty of seven physicians plus 13 Madison-area doctors who serve as clinical faculty members.

Donald R. Griffith, MD*

. . . Midelfort Clinic, Eau Claire, recently was elected as a trustee of the American Association of Medical Clinics at its Annual Meeting.

William E. Raduege, MD*

. . . recently became associated with the Lakeland Medical Associates, Ltd., Woodruff. Doctor Raduege had been practicing in the Rusk County area for three years prior to joining the Lakeland Clinic.

Constante Avecilla, MD

. . . recently became associated with the Marshfield Clinic. He is a graduate of the University of the East College of Medicine and has served on the medical staffs of St. Barnabas Medical Center, Livingston, N. J.; Presbyterian Hospital, Dallas, Tex; and Memorial Hospital in New York. Doctor Avecilla is certified by the American Board of Surgery and the Board of Colon and Rectal Surgery.

Robert L. Keener, MD

. . . Antigo, recently joined the medical staff of the Antigo Medical Center. He graduated from Ohio State University College of Medicine and served his internship at University Hospital, Columbus, Ohio. Doctor Keener served in the United States Air Force for two years and previously had been in medical practice in Frankfort, Ill., for 14 years.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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PHYSICIAN BRIEFS . . .

L. Mark Williamson, MD*

. . . Kenosha, recently accepted the appointment as medical director for American Motors Corp. in Kenosha. He had been medical director at the Southern Wisconsin Colony, Union Grove, and also maintained a private practice at Wausau for 13 years. He graduated from the University Medical School, Santiago, Chile, and did specialized training at the Mayo Clinic and University of Minnesota.

Lindley Sprague, MD*
Marriott Morrison, MD*
Edwin Schneiders, MD*

. . . recently received the Madison Area Chapter of the Wisconsin Academy of Family Physicians' "Merit Award." Doctor Sprague, an emeritus clinical professor at the University of Wisconsin Medical School, has practiced medicine in Madison since 1926 and is presently associated with the East Madison Clinic. Doctor Morrison had practiced medicine in Mt. Horeb before becoming admissions officer and personnel physician at the Veterans Hospital, Madison. Doctor Schneiders, practicing obstetrics and gynecology since 1923, was associated with the Dean Clinic until retiring in 1971. For many years he was an associate clinical professor of obstetrics and gynecology at the University of Wisconsin in Madison.

V. J. Hittner, MD*

. . . Seymour, recently was honored by the Seymour Kiwanis Club for his work and contributions to the Seymour community for over 50 years.

John S. Hirschboeck, MD*

. . . Milwaukee, coordinator of the Wisconsin Regional Medical Program, Inc. since 1966, recently became coordinator of medical services at St. Mary's Hospital, Milwaukee. Doctor Hirschboeck served as dean of the school of medicine of Marquette University from 1947-1965 and vice-president of Marquette in 1965 and 1966. He also is a member of the board of trustees of Loyola University, Chicago, and serves on the board of directors of the Catholic Society Services of the Milwaukee archdiocese. In 1972, the Wisconsin Hospital Association gave its award of merit to Doctor Hirschboeck.

John F. Morrissey, MD*

. . . of the Department of Medicine, University of Wisconsin Medical School, Madison, recently returned from London, England, where he delivered the Second Foundation Lecture to the British Society for Digestive Endoscopy. The topic of his lecture was "The Future of Gastrointestinal Endoscopy." Following his lecture, Doctor Morrissey was elected to honorary membership in the Society.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1973

1	Madison Surgical Society
2	Wisconsin Work Week of Health
2	Madison Anesthesiology Society
2	Madison Urological Society
2	Dane County Medical Society Board of Trustees
3	Wisconsin Work Week of Health
4	Wisconsin Work Week of Health
9	Dane County Medical Society Annual Meeting
9	Perinatal — Pediatric Program
10	Board of Directors, Wisconsin Regional Medical Program
11	SMS Ad Hoc Committee on Chiropractic
14	SMS Division on Nervous and Mental Diseases
15	Central Committee Aesculapian Society
16	Trained Practical Nurse Exams
17	SMS Grievance Committee
18	Madison Area Radiologists
22	Dane County Medical Society Utilization Review Committee
24	Finance Committee of SMS Council
24	Trustees of SMS Realty Corp.
25	Task Force on Health Education
25	Joint Committee on Formulary
26	SMS Commission on Scientific Medicine
29	Dane County Medical Society Ad Hoc Committee on Foundations
30	Wisconsin Community Health Nurse Association
31	SMS Committee on Occupational Health

Meetings not held in the Society "Home" but which have o direct relationship ore printed in itolics with the locotion in porentheses.

and president-elect; Alvin Greenberg, MD, Madison, secretary; and Maurice Greenberg, MD, Milwaukee, treasurer.

The Society meets quarterly in February, May, August, and November in selected sites throughout Wisconsin at the discretion of the President of the Society. The most recent meeting on November 17 in Milwaukee honored the immediate past president of the Society, Frank Ellis, MD of Milwaukee who is leaving to assume a post at the Memorial Hospital for cancer and allied diseases in New York City. Doctor Ellis has been director of radiation therapy at the Medical College of Wisconsin the past two years.

Madison's Family Medicine and Practice Facility Dedicated

On October 12 in Madison the University of Wisconsin Center for Health Sciences and St. Marys Hospital Medical Center joined in dedicating a Family Medicine and Practice facility at St. Marys. John H. Renner, MD,* Director of the Family Practice Program, as master of ceremonies, cited the facility as a joint venture in medical education, research, and service for the people of Wisconsin. An open house at the Family Practice Clinic, located adjacent to the hospital, followed the dedication.

Physicians participating in the program were MDs Robert Cooke, vice-chancellor for health affairs, University of Wisconsin Center for Health Sciences; Marc Hansen,* director of the Program in Primary Care and professor of pediatrics; Gerald Derus,* family physician and president of the State Medical Society of Wisconsin; Richard Shropshire,* family physician and chairman of the board, Wisconsin Academy of Family Physicians; William Rock,* internist and clinical teacher; Curtis Bush, third-year resident in family medicine; and Doctor Renner.

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Robert W. Edland, MD*

. . . La Crosse, was recently elected to the office of secretary in the American Society of Therapeutic Radiologists at the 15th annual meeting in New Orleans, La. This Society, the official organization for radiologists specializing in therapeutic radiology which has membership throughout this hemisphere, now has over 900 members. Doctor Edland is chairman of the Department of Radiation Oncology at the Gundersen Clinic in La Crosse and is associate clinical professor of radiology at the University of Wisconsin-Madison Medical School in Madison.

M. Tim Dunfee, MD

. . . recently became associated with MDs L. M. Baertsch,* J. F. Hussa* and P. Strapon, III* (Baertsch Medical Group) at the Hayward Medical Center, North, Hayward. He graduated from the Indiana University School of Medicine and served as a physician with the United States Army at Brooks General Hospital, San Antonio, Tex., and at the 24th Evacuation Hospital in Vietnam. His residency was completed at St. Vincent Hospital, Indianapolis, Ind.

Lester A. Thompson, MD

. . . Rice Lake, recently became affiliated with the staff of the Indianhead Medical Group, Ltd. in Rice Lake. He received his medical degree from the University of Chicago and had served his internship at University Hospitals in Madison. Doctor Thompson also served with the United States Public Health service on the Navajo Indian Reservation in Arizona and had a year of general practice at Dillon, Colo.

F. J. Rueda, MD

. . . Burlington, recently joined the medical staff of the Burlington Clinic. A graduate of the University of N.L. Medical School in Mexico, Doctor Rueda had previously practiced in Baltimore, Md., and Virginia.

Jeffrey C. Thomas MD

. . . Janesville, recently became associated with the Janesville Orthopaedic Surgery Group founded by his father, George Thomas, MD.* Doctor Thomas completed his orthopedic training at the University of Wisconsin in Madison.

Patricia J. Stuff, MD*

. . . Bonduel, recently was featured in the Women's section of the APPLETON POST CRESCENT. Doctor Stuff was cited for her becoming the first woman officer of the State Medical Society in its 132-year history. She was elected vice-speaker of the House of Delegates of the State Medical Society and serves as an ex-officio member of its Council (board of directors). Doctor Stuff, a family physician, wife, and mother of three teenagers, has managed to find time for hobbies, to plan and decorate her home, and do some teaching. She also was instrumental in establishing a mental health clinic in Shawano County. She graduated from the Medical College of Pennsylvania in Philadelphia and served her residency at the University of Colorado Medical School. She met her husband Dr. William Grover* at the Colorado Medical School where he was on the teaching faculty, and after serving her internship at St. Luke Hospital in Chicago, they moved to Bonduel and set up a joint medical practice in 1957. □

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Shown above is one of the card selections

A. CHRISTMAS AT OLD FORT CRAWFORD MILITARY HOSPITAL—Dry point etching with pastels of the restored military hospital at Old Fort Crawford, Prairie du Chien, site of CESF medical museum. Inside 5"x7" card description tells of museum and fort opposite greeting: "Merry Christmas and Best Wishes for the New Year."

ORDERS NOW BEING TAKEN FOR THE STATE MEDICAL SOCIETY OF WISCONSIN

Christmas Cards

featuring

A. Christmas at Old Fort Crawford Military Hospital
B. Evergreen Park Cottage Sanatorium
C. Harvey Hospital
D. A Country Doctor's Christmas
E. Christmas at Fort Howard, Green Bay
F. Horse and Buggy Doctor
G. S. S. HOPE

A special project of the Woman's Auxiliary to the State Medical Society of Wisconsin for the benefit of the

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION

Box of 25: $2.50/See order form on page 59

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

OBITUARIES

Karl P. Ruppenthal, MD, 72, Bangor, died Aug. 19, 1973 in Bangor.

Born on Dec. 21, 1900 in Cascade, Wis., Doctor Ruppenthal graduated from Marquette University School of Medicine in 1926 and served his internship in St. Joseph's Hospital, Milwaukee. He practiced briefly in Racine, and then in West Salem where he spent two years before coming to Bangor in 1928. During his many years of practice, Doctor Ruppenthal was chief of staff of St. Francis Hospital, president of the La Crosse Lutheran Hospital staff, president of the La Crosse County Medical Society, and was the health officer for Bangor for 36 years. He had retired from active practice in 1970.

He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Mary; two sons, Kenneth, Orinda, Calif.; and John, Pleasant Hill, Calif.; and a daughter, Mrs. Karol Berscheid of Dublin, Calif.

Anthony F. Rufflo, MD, 74, prominent Kenosha physician since 1927, died Aug. 20, 1973 in Kenosha.

Born Feb. 6, 1899 in Kenosha, Doctor Rufflo graduated from the University of Illinois Medical School in 1926 and served his internship at Milwaukee Hospital, now Lutheran Hospital. Doctor Rufflo served on the Wisconsin State Medical Examining Board from 1941-1954. He was a member of the American Academy of Family Physicians and was on the medical staff of Memorial and St. Catherine's hospitals. He was preceded in death by a son, Dr. Robert A. Rufflo of Milwaukee.

He was a member of the Kenosha County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

EDITORIAL

The Country Doctor

Stratford residents are in mourning this week for a man who was close to the hearts of many in that Marathon County community. Dr. Frederick C. Kroeplin was a member of a virtually vanished breed—a medical practitioner who remained and served in one place for more than 40 years.

It is our understanding that Stratford is the only place where Dr. Kroeplin ever served as a resident physician, having settled there some 43 years ago immediately after completing the medical training required for the establishment of a practice. He continued to live and work there until his death last Sunday.

During recent years his own health was such as to curtail his activities, but many of his patients recall the days when, in keeping with the habits of his generation of practitioners, he traveled the countryside by day and into night to minister to their needs.

Technical progress in the medical field during recent decades has been almost unbelievable, and as a result the skills of the medical fraternity have been tremendously enhanced. But no amount of modern training and technology can instill in today's physicians greater dedication or devotion to their fellow men than the healers of Dr. Kroeplin's generation displayed.—MARSHFIELD NEWS HERALD, Sept. 11, 1973

Surviving are his widow, Hilda; a son, Donald of Kenosha; and three daughters, Mrs. James (Janet) Mross, Greendale; Mrs. Lawrence (Antoinette) Waddick, Wauwatosa; and Mrs. Paul (Nancy) DiGaudio, Orinda, Calif.

John McCabe, MD, 78, physician and former lecturer in the department of pathology at Marquette University School of Medicine, died Sept. 6, 1973 in Austin, Tex.

Doctor McCabe was born in Waupaca, Wis., and graduated from the Marquette University School of Medicine in 1926. He had practiced in Milwaukee until his retirement in 1968. He was an instrumental physician in the founding of Surgical Care-Blue Shield Plan in Milwaukee and also a founder and first president of the Catholic Physicians Guild. Doctor McCabe was a past president of The Medical Society of Milwaukee County and served three terms as chief of the medical staff at St. Anthony's Hospital in Milwaukee.

He was a member of the Milwaukee Academy of Medicine and a founding member of the American and Wisconsin Academy of Family Physicians. He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Margaret; a daughter, Mrs. Fred (Rosemary) O'Neil, Brookfield; and two sons, Dr. Robert, Fox Point, and the Rev. Richard, of Austin, Tex.

Frederick C. Kroeplin, MD, 71, Stratford, died Sept. 9, 1973 in Stratford.

Born on June 14, 1902 in Granville, Wis., Doctor Kroeplin graduated from Marquette University School of Medicine in 1930 and served his internship at Milwaukee County General Hospital. Doctor Kroeplin had practiced in Stratford since 1930, was active in community affairs, and was a member of the Selective Service System for 31 years. He was a member of the American Academy of Family Physicians and a past president of its Wisconsin Valley Chapter.

He also was a member of the Marathon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lillian; two children and four grandchildren.

Thomas W. Dorr, MD, 51, former Wauwatosa physician, died Sept. 29, 1973 in Tampa, Fla.

Surviving are his widow, Nancy; one daughter, Mrs. Laurel Coyne, Chicago; and two sons, Timothy and Michael of Tampa, Fla.

Mead Burke, MD, 79, prominent retired Madison physician, died Oct. 4, 1973 in Madison.

Born on Sept. 17, 1894 in Chicago, Ill., Doctor Burke graduated from the University of Wisconsin in 1917 and from Rush Medical College in 1927. He served his internship at Research and Educational Hospital of the University of Illinois in Chicago.

Doctor Burke taught in the department of pathology at the University of Wisconsin from 1936-1942. He was acting-assistant superintendent of University Hospitals, Madison, from 1942-1944 when he resigned to accept a fellowship at the Asthma, Hay Fever, and Allergy Foundation in Cleveland, Ohio.

Doctor Burke also served with the United States Army during World War I. He was in practice with his wife, Myra E. Burke, MD until his retirement in 1968.

He was a member of the Dane County Medical Society, American Academy of Allergy, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Myra. □

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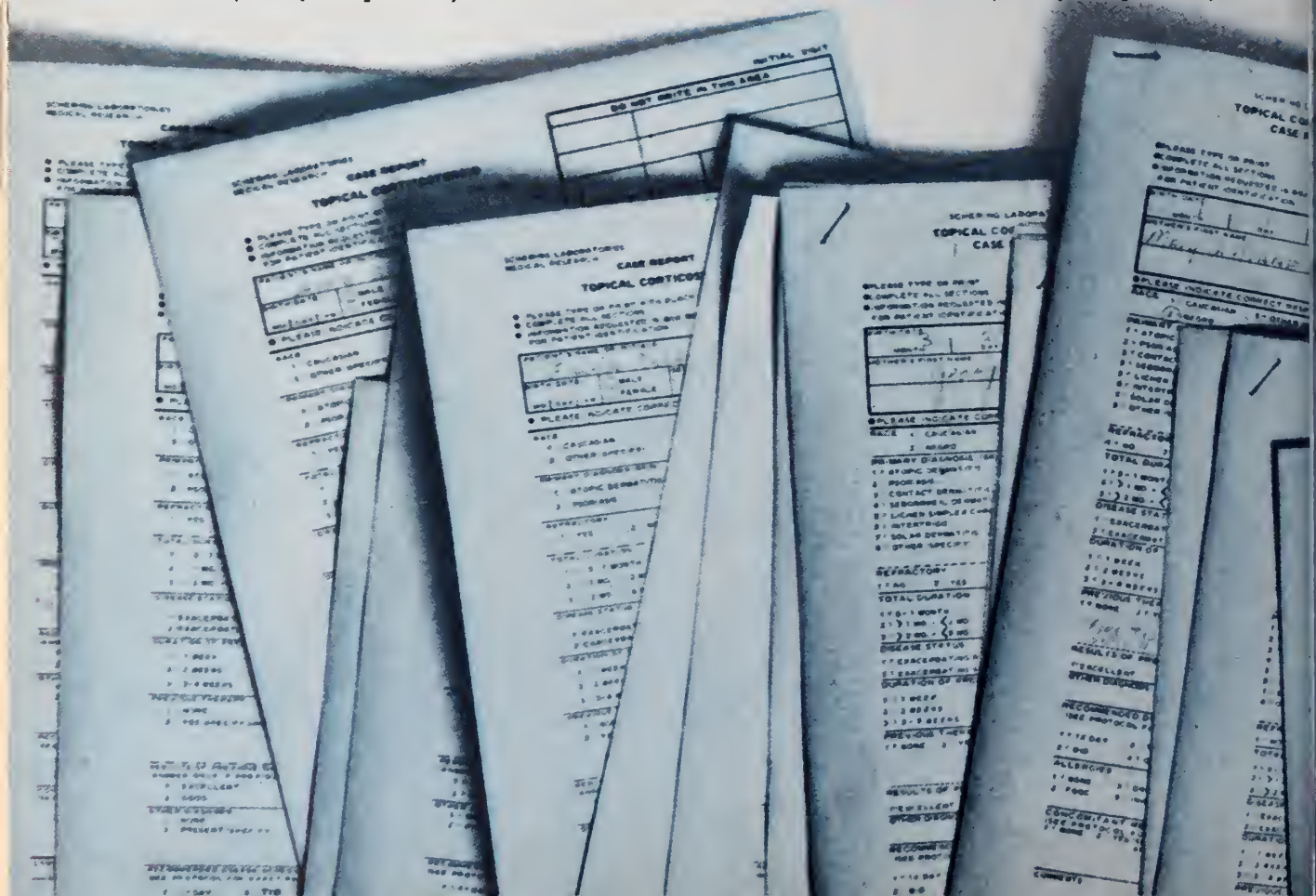
in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic eczem *(231 of 251 patients)*[1]



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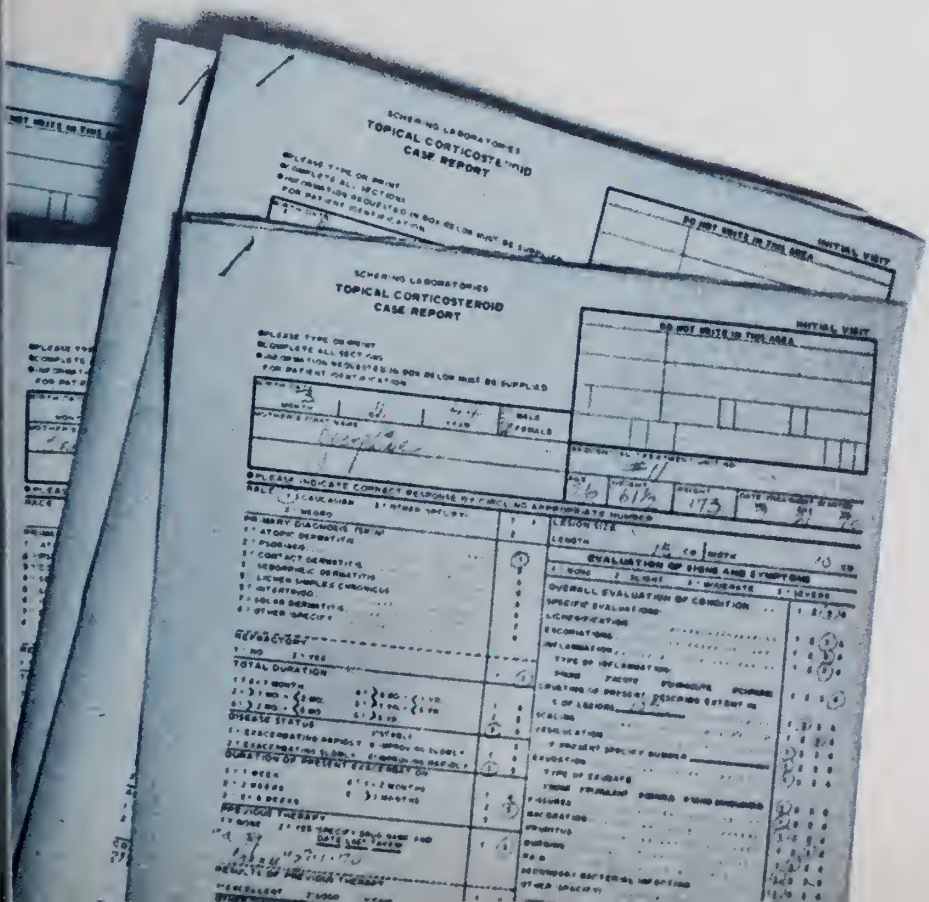
Plus economy *B.i.d. dosage often found effective.*[1]
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis
(81 of 84 patients)[1]



CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11β,17,21-trihydroxy-16β-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 1000 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Each gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not been absolutely established. Therefore, they should not be used extensively in pregnant patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLR-439

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 21, 1973

NEW MEMBERS

Babbitz, Allen H., 675 Moorland Rd., Madison 53713
Booth, Alan Z., 21400 W. Candlewood Dr., Waukesha 53186
Carrel, Drew, 5714 Odana Rd., Madison 53711
Daleiden, James P., 1111 Delafield, Waukesha 53186
Dannenberg, Lee, N88 W16624 Appleton Ave., Menomonee Falls 53051
Ford, Charles N., Jr., 1836 South Ave., La Crosse 54601
Gutenberger, James E., 1313 Fish Hatchery Rd., Madison 53715
Hecht, Rudolph C., 1659 Sherman Ave., Madison 53704
Helling, R. David, W26149 Canterbury, Waukesha 53186
Herrmann, Richard, 17030 W. North Ave., Brookfield 53005
Jones, William W., 2211 Stout Rd., Menomonie 54751
Kincaid, Daniel T., 733 W. Clairmont Ave., Eau Claire 54701
Kitzman, Robert H., Spring Lake Rd., Rhinelander 54501
Knutson, Susan M., 733 W. Clairmont Ave., Eau Claire 54701
Liang, George C., 1836 South Ave., La Crosse 54601
Linden, Richard P., R. R. #2, Box 180, Eau Claire 54701
Miller, David K., 1836 South Ave., La Crosse 54601
Morcinek, Alphonse F., 204 Baldwin St., Sharon 53585
O'Halloran, Michael J., 733 W. Clairmont Ave., Eau Claire 54701
Olson, Carl E., 5114 Juneau Rd., Madison 53705
Ortiz, Simeon B., 1138 Geneva St., Delavan 53115
Peters, Mary Ellen, 1804 Kendall Ave., Madison 53705
Podoll, Lee N., 1307 Theresa Terr., Madison 53711
Sheldon, Warner F., 310 Chestnut St., Eau Claire 54701
Siegel, Robert J., Route #1, Elkhorn 53121
Ujda, John R., 212 South 11th St., La Crosse 54601
Wertsch, Paul A., 5001 Monona Dr., Madison 53716
Williams, James K., 1836 South Ave., La Crosse 54601

CHANGE OF ADDRESS

Armagan, Senekerim, 5820 S. Packard Ave., Cudahy 53110
Beatty, Samuel R., 309 West New York Ave., Oshkosh 54901
Benish, George A., 1206 Sherman Ave., Madison 53703
Bogle, Warren C., 11622 West North Ave., Wauwatosa 53226
Brazy, Robert R., 11622 West North Ave., Wauwatosa 53226
Buck, Charles R., Route A., Box 417-D, Chapel Hill, N.C. 27514
Calogeris, Constance, 424 Bellflower Blvd., Long Beach, Calif. 90814
Chase, Jules, 4708 North Oakland Ave., Milwaukee 53211
Dennis, Susana R. K., P.O. Box 2599, Madison 53701
Deoras, Mukund P., Mount Sinai Hospital, University Circle, Cleveland, Ohio 44106
Duffy, Haydon R., 5148 North Teutonia, Milwaukee 53209
Dunkelberger, L., 100 Northeast Randolph, Peoria, Ill. 61606
Faber, John W., 1424 South Commercial St., Neenah 54956
Franklin, Richard L., 1218 West Kilbourn Ave., Milwaukee 53233
Garner, Lawrence L., 939 Coast Blvd., La Jolla, Calif. 92037
Gumerman, George J., 137 Rancho Vista, Prescott, Ariz. 85301
Guten, Gary N., 1218 West Kilbourn Ave., Milwaukee 53233
Halbert, Helen E., 2858 Scenic Dr., R.R. #2, La Crosse 54601
Han, Paul Zung-Ying, 1008 McIndoe St., Wausau 54401
Hootkin, Lawrence A., 1218 West Kilbourn Ave., Milwaukee 53233
Jacobs, Paul A., 1218 West Kilbourn Ave., Milwaukee 53233
Jaeck, James L., 614 Memorial Dr., Chilton 53014
Just, John F., 10625 West North Ave., Milwaukee 53226
Kaufman, Kiesl K., 1218 West Kilbourn Ave., Milwaukee 53233
Korst, Donald R., 1300 University Ave., Madison 53706
Lane, George H., 13213 West Capitol, Milwaukee 53222
Larson, Arthur N., Route 5, Bartlett St., Huntington, Ind. 46750
Lipman, William H., 666 Upas St., San Diego, Calif. 92103
Mateicka, William E., 11622 West North Ave., Wauwatosa 53226
McCabe, John O., 2500 North Mayfair Rd., Milwaukee 53226
Nellen, James R., 6287 Parkview Rd., Greendale 53129
Rhomberg, Bernard B., 11622 West North Ave., Wauwatosa 53226
Romero, Ruben P., 4823 South 23rd St., Milwaukee 53226
Rossmann, Hermann K., 209 Fuller Lane, Winnetka, Ill. 60093
Saladar, Rafael S., 2460 Blarney Stone Dr., Beloit 53511
Sather, R. Alan, 1600 North Phillips, Oklahoma City, Okla. 73104
Schaeffer, Bernard S., 2040 West Wisconsin Ave., Milwaukee 53233
Sipes, Donald R., 720 Marquette St., Green Bay 54304
Solidum, Ruben R., 615 Midge St., Reedsburg 53959
Stone, Joseph R., 1218 West Kilbourn Ave., Milwaukee 53233
Storms, William W., 533 Shady Wood Way, Madison 53714
Taylor, Thomas F., W318 N846 Clover Park Ct., Delafield 53018
Wells, Marvin, 2040 West Wisconsin Ave., Milwaukee 53233
Ylagan, Arturo M., 251 East Main St., Chilton 53014

DEATHS

Pfefferkorn, Ethan B., Clark County, June 6, 1973
Ruppenthal, Karl P., La Crosse County, Aug. 19, 1973
Kroeplin, Frederick C., Marathon County, Sept. 9, 1973 □

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, and MISCELLANEOUS. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. BOXED AD RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the first of the month preceding month of issue; e.g., copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257–6781. 12tfn

WANTED: GENERAL PRACTItioner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

INTERNIST: WANTED TO JOIN a multi-specialty group (internist, surgeon, ob-gyn, and GPs) in the "Home of the Packers." Excellent school facilities and two universities. Excellent modern airport with connections all over the country. New clinic building affords the ultimate in practice facilities with one of our three modern, well-equipped hospitals at the back door. Starting salary of $40,000 with percentage bonus leading to partnership after one year; no buy-in required. For more complete information write or call: S. E. Milson, MD, Dousman Clinic, 1745 Dousman St., Green Bay, Wis. 54303. Tel: 414/494–9661 (phone collect). 5–10/73

IMMEDIATE OPENING FOR OB–Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1–12/73

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY OR GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months. Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Family Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 10-12/73

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB-GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn/72

LAKE SUPERIOR CALLING WELL trained family practitioners, internists, pediatricians, otolaryngologist or urologist eager to practice where skills will be fully used and appreciated by the people living in Ashland and surrounding drawing area, 120,000 in all. Brand new 101-bed hospital with 5-bed ICU/CCU and extremely well equipped lab headed by full-time pathologist. Memorial Medical Center also has two full-time radiologists and complete range of x-ray facilities. Continuing education programs for medical, nursing and ancillary staffs. Other physicians practicing in Ashland: 3 ophthalmologists, 1 Ob-Gyn specialist, 1 psychiatrist, 1 internist, 1 new, busy general surgeon, and general practitioners. Progressive school system, new high school, vocational school and 4-year college. Need guarantee? A generous one is available. To arrange expense paid visit, write, sending CV to Fred Tidstrom, MD, 600 14th W., Ashland, Wis. 54806, or call collect after 6:00 pm, Ken Morrow, MD, 715/682-5321. g11/73

THE MONROE CLINIC IS INTERviewing Surgical and Medical Specialists to join the present 39 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical and Surgical Specialties:

1. Urology
2. Obstetrics and Gynecology
3. Orthopedic Surgery
4. Otolaryngology
5. Family Practice
6. Gastroenterology
7. Cardiology
8. General Internal Medicine

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 9tfn/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD, or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel. 608/339-3326. 6tfn/72

KROHN CLINIC, LTD., NEEDS physician interested in rural family practice. Group of six presently includes five ABFP plus board surgeon. Excellent situation for young physician, preferably not over 32, and desiring interesting variety in practice. New clinic building and new 70-bed hospital. Contact Wm. B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams St., Black River Falls, Wis. 54615, or call collect 715/284-4311. 10tfn/73

INTERNIST OR FAMILY PHYSIcian to practice in established clinic. Attractive city of 4000, plus surrounding area. Near Madison. 75-bed hospital with plans for expansion. Contact Dept. 399 in care of the Journal. 10-12/73, 1-3/74

GENERAL PRACTITIONER wanted: Multi-specialty group practice in Milwaukee suburb. New clinic building. Excellent hospital nearby. Fine salary and benefit program. Contact: Mr. R. R. Grigg, 3533 East Ramsey Ave., Cudahy, Wis. 53110. 10-12/73

FAMILY PRACTICE OPENING January, 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreational opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, MD (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815. Tel: 509/782-1541. 9/73-8/74

ENJOY THE BEST OF TWO worlds! Discover Watertown, Wisconsin. No traffic congestion, smog, crime or other big city unpleasantness. Peaceful environment with new 100-bed general hospital and new connecting (but separate) medical office building. Good location to Madison and Milwaukee medical centers. Medical practice area includes over 40,000 people. Progressive community. New schools. Many parks, trees and recreational facilities. Stable economy. If you are a family practitioner, an internist, an orthopedist, and interested in a new solo or group private practice, write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261-4210. 10-12/73

LOCUM TENENS NEEDED IN two-man practice in Tomahawk, Wis., for one to two weeks between 12/19/73 and 1/9/74. Rotating work days allow for winter recreation time. Compensation very adequate. For further information call collect 715/453-2147. 10-11/73

EXCELLENT OPPORTUNITY: GP or FP for busy established incorporated practice in thriving community of 6800. Superior educational and recreational facilities. Modern well-equipped clinic adjacent 85-bed hospital. Starting salary open, partnership after one year. Phone, visit, or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372-4177. 10tfn/73

WANTED: GENERAL PRACTItioner in city of Markesan, Green Lake County, Wis., to join two AAFP members, so that we can all enjoy more normal time for relaxation and family life. Salary first year, partnership thereafter. Contact D. P. Cupery, MD, Markesan Medical Center, P.O. Box 247, Markesan, Wis. 53946. 8-12/73

THE WAUSAU MEDICAL CENTER (formerly Wausau Clinic), a family medicine-multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. General Surgery
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry
7. Family Medicine

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospial insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842-0411. 10-12tfn/73

LOCUM TENENS AVAILABLE AT intermittent times doing family practice or emergency medicine. Contact Dept. 401 in care of the Journal. 10-11/73

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis. Tel.: 414/637-9271. 4tfn/72

GPs URGENTLY NEEDED TO JOIN a new four-man corporate practice located in central Wisconsin. Excellent recreational area, small town living within 40 minutes drive to Appleton and Green Bay. New fully equipped hospital and adjacent clinic facilities. Good salary, benefits with early equity. Excellent opportunity for sharing in growth development. Contact Dept. 398 in care of the Journal. 9-11/73

WANTED: GP TO JOIN 3-MAN group, Wild Rose Clinic, Ltd. in Central Wisconsin vacationland. Clinic located next to new, modern hospital. Salary negotiable. Call 414/622-3329. 11tfn/73

IMMEDIATE OPENINGS FOR family practice, Ob/Gyn, pediatrics to join young expanding group. Wisconsin license or reciprocity. Top salary and fringe benefits. New clinic and excellent hospital facilities adjacent to clinic. Also solo practice available. New churches, schools, and outstanding outside recreational activities. Call collect, Les Hirt, Doctors for Medford, Medford, Wis. 54451. Tel: 715/748-4100 or 715/748-3726. 9-11/73

WISCONSIN MULTI-SPECIALTY group of 17 physicians has openings in the following specialties: Internal Medicine, presently six men, general or subspecialty training; Otolaryngology, presently one-man department; Allergy, an excellent opportunity as this specialty is not covered in our community. Attractive starting salary, no investment, corporate organization, exceptional pension and insurance programs, progressive community of 45,000. Include curriculum vitae with correspondence. For further information please contact Francis R. Russo, MD, Janesville Riverview Clinic Ltd., Box 551, Janesville, Wis. 53545. 9tfn/73

INTERNIST AND PEDIATRICIAN wanted: Incorporated group of three general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Anyone interested write to Dr. I. E. Schiek, Jr. or Dr. Otto G. Rosemeyer, c/o The Schiek Clinic, S.C., Rhinelander, Wis. 54501, or call collect 715/362-6160. 11-12/73, 1-10/74

THE MARSHFIELD CLINIC IS seeking additional specialists in many areas. This opportunity combines a busy, stimulating referral practice plus an active local practice with an opportunity for family medicine. We provide excellent salary and fringe benefits as well as opportunities for research and teaching. Excellent retirement program and insurance plan. Modern 7-story office building with all diagnostic facilities available. Excellent 400-bed hospital. We are looking for physicians in the following specialties:

1. Pediatrics—General—Hematology
2. General Surgery
3. Orthopedic Surgery
4. Plastic Surgery

For further information, please contact Russell F. Lewis, MD, Medical Director, Marshfield Clinic, Marshfield, Wis. 54449. 11-12/73, 1-2/74

THE MEDFORD CLINIC HAS IMmediate openings in OB-GYN and general practice. Excellent adjacent 110-bed hospital. Beginning salary $30,000. Retirement and other group benefits. Participation in corporation available but not required. Contact: Walther W. Meyer, MD, 101 N. Gibson Ave., Medford, Wis. 54451. Tel: 715/748-2121. 11-12/73, 1-4/74

SECOND GENERAL PRACTITIONER needed by eleven man multi-specialty clinic. One aspect of this position is to also share in the practice of industrial medicine. Limited night call, if any. Salary negotiable, many fringe benefits. Associate status possible after one full calendar year. Contact: Administrator, Medical-Surgical Clinic, S.C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215 11-12/73, 1-4/74

GENERAL PRACTITIONER AND psychiatrist openings. Expanding program in 430-bed university-affiliated hospital. Attractive hours, liberal fringe benefits, excellent retirement plan. Starting salary in the $28,000 to $34,000 range. Contact Chief of Staff, VA Hospital, Madison, WI 53705. Phone 608/256-1901, ext. 311. Nondiscrimination employer. 11-12/73, 1/74

LOCUM TENENS NEEDED FOR one or two weeks in January 1974. Two-man family practice, one unable to work for a few months, I will need a "breather." Beautiful northwoods. Compensation adequate. O. M. Francisco, MD, 221 E. Washington Ave., Tomahawk, Wis. 54487. Tel: 715/453-2147. p11/73

FAMILY PRACTITIONER, INTERNist, Pediatrician, Orthopedist, OB-GYN —Board Certified or Board Eligible— wanted by expanding multispecialty group in Madison, Wis. City has university, excellent hospitals, schools, and recreational facilities. Immediate openings. Salary competitive. Write: Mr. Robert W. Graff, Bus. Mgr., 2 W. Gorham St., Madison, Wis. 53703. p11-12/73, p1-2/74

PEDIATRICIAN, BOARD ELIGIble, certified, to join three pediatricians with own building, lab, and x-ray, in well established Milwaukee suburban practice. Childrens hospital 15 minutes away. Send curriculum vitae. K. J. Winters, MD, 949 Glenview Ave., Wauwatosa, Wis. 53213. 11-12*/73

MEDICAL DIRECTOR
ASSISTANT MEDICAL DIRECTOR
STAFF PHYSICIANS

Above positions now available in a large state residential facility for the developmentally disabled. Complete medical program, well staffed and based in a recently constructed, modernly equipped 120-bed general hospital. Hospital includes diagnostic and evaluation, surgical, physical medicine, acute, chronic and isolation units. Paramedical facilities include EEG-EKG, X-Ray, Medical Laboratory, Pathology, Pharmacy, Occupational Therapy and Physical Therapy departments. Starting annual salary up to $37,248 for Medical Director, $36,048 for Assistant Medical Director, and $33,648 for Staff Physicians. Periodic yearly increases and excellent fringe benefits. Contact Dennis E. Zoltak, Director of Care and Treatment Services at 878-2411, extension 360, Southern Wisconsin Colony & Training School, Union Grove, Wis. 53182. "An Equal Opportunity and Affirmative Action Employer." 11/73

IMPORTANT NOTICE: IF YOU are one of the hundreds of parachuting enthusiasts who bought our course entitled Easy Sky Diving in One Fell Swoop, please make the following correction: On page 8, line 7, change "state zip code" to "pull rip cord."—EDITOR NORMAN COUSINS in World Magazine 11/73

PRACTICES AVAILABLE

GP NEEDED TO REPLACE DEceased MD in established practice. Entire inventory for sale, excellent hospital facilities, good school in resort and recreational area. SE Wisconsin. Contact Box 457, Williams Bay, Wis. 53191. g6tfn/73

RETIRING PHYSICIAN WANTS to rent his office space. Active practice and equipment included in rent. Southeastern Wisconsin city with 48,000 population. June availability possible. Tel: 414/542-9114. 4tfn/73

MEDICAL FACILITIES

EXCELLENT OPPORTUNITY FOR pediatricians and internists to establish practice in beautiful new physicians condominium building adjacent to Bellin and St. Vincent hospitals in Green Bay, Wis. Patients immediately available on referral from other physicians in the building. Call or write H.F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748-3636. g4tfn/73

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn/72

NOW LEASING FOR LATE 1974 occupancy, a new medical building connected to a 275-bed hospital in the rapidly growing northeast suburb of Minneapolis. Suites will be custom designed to suit individual tenants. For further information, contact J. L. Harty, MD, c/o Unity Hospital, 550 Osborne Road, Fridley, MN 55432. Phone: 612/786-2200. 11-12/73

MISCELLANEOUS

GUIDELINES FOR BLOOD—ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

WANTED: ADVERTISEMENTS for this section. Open to physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

FOR SALE: CHARMING CIVIL war era brick colonial house, set among ancient oak trees. Four bedrooms, 2½ baths, slate entry, double fireplace, indoor barbecue, 20x38 swimming pool. Acreage and other buildings if desired. Bus pickup at front door to accredited schools. Contact Dept. 402 in care of the Journal. 11/73

FOR SALE: PICKER G200S CENtury II x-ray unit, complete with collimator, twin track tube stand with magnetic locks, tilt table with Bucky generator and central unit—all solid state. Unit installed new in February 1973. $8,500. Call 608/489-2253. 11/73

ANNOUNCEMENTS

ADVISORY PANEL FOR FAMILY PLANNING AND BIRTH CONTROL ESTABLISHED. An Advisory Panel for Family Planning and Birth Control, each member of which is a Diplomate of the American Board of Obstetrics & Gynecology, has been established by A. H. Robins Company, Richmond-based pharmaceutical manufacturer.

The company, which produces the Dalkon Shield®, an intrauterine contraceptive device, and Dalkon Foam™, a contraceptive foam, is sponsoring the panel as a free service to physicians active in family planning and birth control.

Panel members will be available to consult with any physician with an inquiry or problem related to intrauterine contraceptive devices or any other birth control method.

Physicians may request a consultation with a panelist through an A. H. Robins representative, or may personally initiate a consultation.

In addition to consulting with private physicians throughout the country, the panelists also will assist the A. H. Robins medical staff in responding to inquiries concerning the Dalkon Shield, Dalkon Foam and other related products which the company may add to its line, and provide consultation to A. H. Robins research personnel in developing new products and initiating clinical studies.

The new panel has five members located in Philadelphia, Detroit, Houston, Los Angeles and San Francisco. The company anticipates that the size of the panel will be increased in the future.

CIBA COLLECTION OF MEDICAL illustrations is being offered to Wisconsin physicians through an advertisement in this issue of the *Wisconsin Medical Journal*. To commemorate the 25th anniversary of the COLLECTION's publication, Ciba will send free, four full-color, 18x24-inch, suitable-for-framing reproductions of nonmedical paintings by the COLLECTION's artist, Frank H. Netter, MD. A handy coupon in the ad is available for ordering. Ad appears following the scientific section.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1973 through Aug. 31, 1974 appeared in JAMA (Supplement) Aug. 13, 1973.*

1973 WISCONSIN

Dec. 6: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin Extension/Madison 1973-1974

ON-CAMPUS CONFERENCES in Continuing Medical Education

Nov. 29-30: *Quality of Care Conference*

Jan. 25-26: *Exercise—As Therapeutic Tool*

Mar. 28-30: *How to Teach Family Medicine*

Apr. 24-26: *Sports Education*

May 2-4: *Emergency Medical Care of Critically Injured*

Aug. 12-16: *Emergency Medical Care*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

Dec. 7-8: Conference in Helpful Clinical, Chest X-ray, and ECG Clues to Congenital Heart Disease, presented by University of Wisconsin Center for Health Sciences, ECG—Computer Service, and UW-Extension/Health Science Unit/Department of Continuing Medical Education, at The Wisconsin Center, Madison.

Dec. 12: Family Practice Off-Campus Conference on Arthritis and Orthopedics, Sacred Heart Hospital, Eau Claire.

Dec 13: Family Practice Off-Campus Conference on Arthritis and Orthopedics, North Hospital, Wausau.

1973 NEIGHBORING STATES

Dec 7: Cardiac and Respiratory Disease Conference, University of Iowa Medical Alumni Auditorium, Room E-331, University Hospital. Info: Office of Continuing Medical Education, University of Iowa, 101 CMAB, Iowa City, Ia. 52242.

1973 OTHERS

Dec. 3-6: 10th Annual New Orleans International Postgraduate Course for Physicians on "Pulmonary Function in Health and Disease." Louisiana State University School of Medicine, New Orleans. Info: Louisiana Thoracic Society, Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130.

1974 WISCONSIN

Jan. 9: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

Feb. 2-3: Council Meeting, State Medical Society of Wisconsin, Madison.

Feb. 12-14: Wisconsin Academy of Family Physicians Winter Conference, Mt. Telemark, Cable.

Feb. 21: Family Practice Off-Campus Conference on Allergies and Lab Test, North Hospital, Wausau.

Feb. 28: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

Mar. 26: Spring meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee.

Apr. 10: Family Practice Off-Campus Conference on Allergies and Lab Test, Sacred Heart Hospital, Eau Claire.

Apr. 17-19: Second annual course for nurses involved in emergency care: "Emergency '74," sponsored by the Wisconsin Committee on Trauma of the American College of Surgeons, at Pfister Hotel and Tower in Milwaukee. Info: Joseph C. Darin, MD, 8700 West Wisconsin Ave., Milwaukee, WI 53226.

Apr. 18: Family Practice Off-Campus Conference on Peptic Ulcer and Breast Cancer, North Hospital, Wausau.

May 8: Family Practice Off-Campus Conference on Peptic Ulcer and Breast Cancer, Sacred Heart Hospital, Eau Claire.

June 21-23: Wisconsin Academy of Family Physicians Annual Meeting, Abbey, Fontana.

Sept. 11-14: Wisconsin Society of Internal Medicine meeting at Telemark Lodge, Cable.

Sept. 13-14: Fall meeting, Wisconsin Surgical Society, Dellview Hotel, Lake Delton.

1974 NEIGHBORING

Jan 25-26: Illinois Regional Meeting, American College of Physicians, Ramada Convention Center, Ramada Inn, Urbana, Ill. Info: Richard Allyn, MD, 107 South 5th St., Springfield, Ill. 62701.

Mar. 18-21: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

Mar. 18-23: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital. Info: Dept. of O, Eye and Ear Infirmary, 1855 West Taylor St., Chicago, Ill. 60612.

Mar. 31-Apr. 6: American Rhinologic Society and Illinois Masonic Medical Center will present introductory course in (A) Functional Corrective Surgery of the Nasal Septum and the External Nasal Pyramid, (B) Rhinomanometry and Naso-Antral Manometry, and (C) Basic Principles of Respiratory Physiology and Fundamental Diagnostic Tests—Pulmonary, Cardiac, Blood Gas Analysis, Nasal Function Tests, and Introducing Naso-Pulmonary Function Tests, in Chicago, Ill. Course approved by AMA Council on Medical Education. Info: Pat A. Barelli, MD, Secretary, ARS, 4177 Broadway, Kansas City, MO 74111.

Apr. 15-19: Clinical Endocrinology: Recent Advances in Diagnosis and Treatment, American College of Physicians, Mayo Clinic, Rochester, Minn.

May 19-31: Cardiac Auscultation, American College of Physicians, Mayo Clinic, Rochester, Minn.

☐ Copy deadline for MEDICAL MEETINGS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

Jun 1-5: Multidisciplinary Workshop in Facial Plastic Surgery, Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois (in cooperation with the American Academy of Facial Plastic and Reconstructive Surgery, Inc.). Info: Dept of O, Eye and Ear Infirmary, 1855 West Taylor St., Chicago, Ill. 60612.

June 10-12: New Diagnostic and Therapeutic Modalities in Internal Medicine, American College of Physicians, University of Iowa, Iowa City, Ia.

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Jan. 22-24: 3rd Annual Pediatric Pulmonary Course, Louisiana State University Medical Center, New Orleans, La. Info: W. Findley Raymond, Exec. Dir., A.L.A. of La., Inc., 333 St. Charles Ave., Suite 1504, New Orleans, La. 70130.

Jan. 26-Feb. 9: 15th Postgraduate Medical Seminar Cruise, Dept. of Postgraduate Medicine of Albany Medical College. Info: Frank M. Woolsey Jr., MD, Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

Apr 28-May 2: American Industrial Health Conference, Americana Hotel, Bal Harbour, Fla. Info: 150 North Wacker Drive, Chicago, Ill. 60606.

May 3-17: 26th Annual Congress and Teaching Seminar of the International Academy of Proctology, Montreux and Zurich, Switzerland. Info: Executive Offices, 147-41 Sanford Ave., Att: Alfred J. Cantor, MD, Exec. Sec., Flushing, N.Y. 11355.

July 7-12: XII International Congress on Diseases of the Chest, sponsored by International Academy of Chest Physicians and Surgeons, affiliated with American College of Chest Physicians, in London, England at Royal Festival Hall. Info: American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings 1974—1978

Mar 23-26, 1974: Pfister Hotel, Milwaukee
Apr 5-8, 1975: Pfister Hotel, Milwaukee
Mar 27-30, 1976: The Madison Hilton, Madison
Mar 26-29, 1977: Pfister Hotel, Milwaukee
Apr 1-4, 1978: Pfister Hotel, Milwaukee
Further information:
David C. Reynolds, Director
Scientific Affairs
State Medical Society of Wisconsin
Box 1109, Madison, WI 53701

Oct. 8-13: Workshops in Hypnosis, in conjunction with 26th Annual Scientific Meeting of Society for Clinical and Experimental Hypnosis, in Montreal, Canada, at Ritz-Carlton Hotel. Info: Germain Lavoie, PhD, Workshops Chairman—SCEH 1974, Hospital Saint-Jean-de-Dieu, Montreal-Gamelin, Quebec, Canada.

1975 WISCONSIN

Apr. 5-8: Annual Meeting, State Medical Society of Wisconsin, Marc Plaza Hotel, Milwaukee.

* * *

Colon Disease and Colonoscopy. Postgraduate education course, designed to improve the diagnosis and treatment of the colon including polyps, cancer and inflammatory bowel disease, offered by The Medical College of Wisconsin departments of gastroenterology and surgery through the office of continuing education.

One-and-a-half day course scheduled for January 25 and 26 at Milwaukee's Pfister Hotel.

Course approved for ten hours of prescribed credit by the American Academy of Family Physicians.

Topics include: Instrumentation and Techniques of Colonoscopy; Carbon Dioxide Insufflation During Colonscopic Electrosurgical Polypectomy; Carcinoembryonic Antigens and Cancer of the Colon; Polyps of Colon: X-ray vs. Colonscopy; Inflammatory Bowel Disease; and Electrosurgery and Cancer of the Rectum.

Course is directed by Joseph E. Geenen, MD, associate clinical professor of gastroenterology at the Medical College. Guest faculty participating are:

Family Practice Off-Campus Conferences

EAU CLAIRE GREEN BAY WAUSAU

Presented by: University of Wisconsin Center for Health Sciences; Department of Continuing Medical Education, Health Sciences Unit, UW-Extension; CES Foundation, State Medical Society of Wisconsin; and Wisconsin Academy of Family Physicians

Dates	*Topics*	*Madison Faculty*	*Eau Claire Faculty*	*Wausau Faculty*
Dec. 12	ARTHRITIS	Mark Mueller, MD	Charles Ihle, MD	
Dec. 12	ORTHO-PEDICS	James Huffer, MD	Richard Kennedy, MD	
Dec. 13	ARTHRITIS	Mark Mueller, MD		Richard Buechel, MD
Dec. 13	ORTHO-PEDICS	James Huffer, MD		Donald Kranendonk, MD
Feb. 21	ALLERGIES	Charles Reed, MD		Norman Deffner, MD David Aughenbaugh, MD
Feb. 21	LAB TEST	Dean Connors, MD		Richard Bartholomew, MD
Apr. 10	ALLERGIES	Charles Reed, MD	Bright Larkin, MD Mrs. M. Johnson	
Apr. 10	LAB TEST	Dean Connors, MD	Robert Fink, MD	
Apr. 18	PEPTIC ULCER	Robert Barreras, MD		Bruce Gargas, MD
Apr. 18	BREAST CANCER	Hugh Davis, MD		Erling Ravn, Jr., MD
May 8	PEPTIC ULCER	Robert Barreras, MD	Joseph Motto, MD	
May 8	BREAST CANCER	Hugh Davis, MD	Ralph Hudson, MD	

Locations

Eau Claire Sacred Heart Hospital/Coordinator: Lou Raymond, MD
Wausau North Hospital/Coordinator: Curt G. Grauer, MD
(Green Bay Conferences: Spring 1974)

16 Hours WAFP Credit Applied For — Individual Sessions: $10

Registration: 9:30 A. M. — Adjournment: 3:30 P.M.

Registration to: Wisconsin Center, 702 Langdon St., Madison, Wis. 53706. Include check for $10 (each session) payable to UW-Extension, name, address, city, zip code, social security number, and phone number.

For more information, contact: Bill Wendle, Department of Continuing Medical Education, Room 560, WARF Building, 610 Walnut Street, Madison, Wis. 53706; tel. 608/263-2855.

MADISON 1973-1974 IN-DEPTH
Workshops and Lectures
TEACHING PROGRAMS

CES Foundation of State Medical Society of Wisconsin
University of Wisconsin Medical School
St. Marys Hospital Medical Center
Madison General Hospital
Wisconsin Academy of Family Physicians
Merck Sharp & Dohme Postgraduate Education Program

January 9/Madison General
Dec. 6, Feb. 28/ St. Marys

WORKSHOPS/MADISON GENERAL

(1) REHABILITATION: ARTHRITIS, AMPUTATIONS, STROKE, MDs RM Krout, RA Sievert

(2) ARRYTHMIAS: CLINICAL AND ECG PROBLEMS, MDs RJ Corliss, JJ Brandabur, TJ Ansfield, JC Buell

(3) BREAST CANCER—CA OF THE BOWEL, MDs RM Carr, TL Carter, Dean Smith, GJ Stuesser, John Schroeder

(4) PEDIATRIC URINARY INFECTION AND ALLERGY, MDs RA Graff, JH Mahler, Hugh Moffet, M Cohen, John Ouellette

LECTURES/DISCUSSIONS

WORKSHOPS/ST. MARYS

(1) CONGESTIVE HEART FAILURE, MDs RJ Hendricks, William Rock; ANGINA PECTORIS, MDs RR Henderson, Louis Bernhardt

(2) PEPTIC ULCER — UPPER GI BLEEDING, MDs TH Browning, EE Skroch

(3) CURRENT MANAGEMENT AND TREATMENT OF ARTHRITIS, WR Sundstrom, MD

(4) UPDATE PULMONARY DISEASE, PNEUMONITIS, PULMONARY FIBROSIS, PNEUMONIA, MDs PO Simenstad, JW Rose; CLINICAL CRITERIA IN THE HOSPITAL MANAGEMENT OF (1) ACUTE MYOCARDIAL INFARCTION, (2) DIABETES MELLITUS, (3) CONVULSIVE DISORDERS, (4) JUVENILE DIABETES, (5) T & A, (6) CHOLECYSTECTOMY, (7) RUPTURED MEMBRANES, (8) IU FETAL DEATH, University of Wisconsin Medical Faculty

When registering, list the Workshops in order of preference. Registration to: In-Depth, Box 1109, Madison, Wis. 53701.

Christopher B. Williams, BM, MRCP, St. Mark's Hospital, London, England; John F. Morrissey, MD, professor of medicine, University of Wisconsin Medical School; B. F. Overholt, MD, professor of medicine, University of Tennessee Medical School, and BH Gerald Rogers, MD, on the staff of Grant and Henrotin Hospitals and a consultant to other hospitals in the Chicago area.

Further info: Dr. Geenen, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226 (Tel. 414-258-2040, Ext. 3133); or Anne T. Finnegan, Conference Planner, The Medical College of Wisconsin (414-272-5450 Ext. 247).

Critical Criteria in the Hospital Management of (1) Premature Rupture of Membranes, (2) Premature Labor, and (3) Intrauterine Fetal Death (20 weeks or more). 1973-1974 In-Depth Teaching Program provided by University of Wisconsin Medical School Faculty, St. Marys Hospital Medical Center, and Madison General Hospital through auspices of the State Medical Society of Wisconsin's Charitable, Educational and Scientific Foundation. Cosponsors: Madison Chapter, Wisconsin Academy of Family Physicians, and Merck Sharp & Dohme Postgraduate Teaching Program.

Date: January 9 at Madison General Hospital. Schedule: 9:00 AM, registration; 10:00 AM, workshops; 1:00 PM, luncheon; 1:30 PM, lecture and discussion; 2:15 PM, lecture and discussion; 3:00 PM, adjourn. Afternoon lectures will be presented by Faculty Members of the UW Medical School.

Registration to: In-Depth, Box 1109, Madison, Wis. 53701. □

THE MEDICAL COLLEGE OF WISCONSIN

Postgraduate Education Programs
1973-74 Academic Year

The Division of Surgery of The Medical College of Wisconsin, through the Office of Continuing Education and with the aid of Eberbach Foundation is sponsoring a series of five Postgraduate Education Conferences during the 1973-74 Academic Year.

1. *Jan. 25, 26, 1974:* "Coloscopy and Colonic Diseases, Diagnostic and Technical Aspects," Joseph E. Geenen, MD, Course Director, Pfister Hotel, Milwaukee.
2. *Feb. 23, 24, 1974:* "Emergency Care," Joseph Darin, MD, Course Director, Pfister Hotel, Milwaukee.
3. *Apr. 20, 21, 1974:* "Vascular Surgery for the Practicing Physician," Victor M. Bernhard, MD, Course Director, Pfister Hotel, Milwaukee.
4. *May 10, 11, 1974:* "Clinical Immunobiology for the Practicing Physician," Glenn Rodey, MD, Peter Abramoff, PhD, Course Directors, Pfister Hotel, Milwaukee.
5. *May 25, 26, 1974:* "Upper Midwest Review of Gastroenterology," Robert Condon, MD, Course Director, Pfister Hotel, Milwaukee.

Above dates and locations are tentative and are provided for information and planning.

WILLIAM F. MC MANUS, MD
Division of Surgery

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Invisible Loyalties. By Ivan Boszormenyi-Nagy, MD and Geraldine M. Spark, MSW. Medical Department, Harper & Row, Publishers, Inc., Hagerstown, Md. 21740. 436 pages. Price: $12.50

Acupuncture Therapy. By Leong T. Tan, MD, Margaret Y.-C. Tan, and Ilza Veith. Temple University Press, Philadelphia, Pa. 19122. 1973. 159 pages. Price: $15.00

Atherogenesis: Initiating Factors. Ciba Foundation Symposium. 1973. Medical Education Division, CIBA Pharmaceutical Co., Division of CIBA-GEIGY Corp., Summit, NJ 07901. 288 pages.

Hard Tissue Growth, Repair and Remineralization. Ciba Foundation Symposium. 1973. Medical Education Division, Pharmaceutical Co., Division of CIBA-GEIGY Corp., Summit, NJ 07901. 455 pages.

Clinical Neurology. By Francis M. Forster, MD, third edition. The C. V. Mosby Co., St. Louis, Mo. 1973. 208 pages. Price: $5.50

Handbook of Chemistry and Physics. 54th edition. Robert C. Weast, PhD, Editor. The Chemical Rubber Co., 18901 Cranwood Parkway, Cleveland, Ohio 44128. 1973. Price: $25.95

Advances in Forensic and Clinical Toxicology. By A. S. Curry. The Chemical Rubber Co., 18901 Cranwood Parkway, Cleveland, Ohio 44128. 1973. 280 pages. Price: $33.50

Practical Automation for the Clinical Laboratory

Second edition, by White, Erickson, and Stevens. The C V Mosby Company, St Louis, Mo, 1972. Pp 591. Price: $22.50

This book contains descriptive and operating details of most of the large high volume automated instruments used in Clinical Laboratories. Over two-thirds of the pages are dedicated to the description of chemical instrumentation reflecting the relatively greater impact of automation in his division of the clinical laboratory. Examples of automated instruments in use in hematology, serology, blood banking, microbiology, and cytology comprise most of the remaining pages of the book. Most automated instruments in use in clinical laboratories are described. There are a few notable and serious exceptions. Among these are the duPont ACA, the most automated of all instruments, and the Vickers M-300, which promises to compete favorably with the Technicon multichannel systems. These, as well as other important instruments, receive mere mention in the first chapter.

The reader should be aware that most of the chapters in the book were written not by the book's author but rather by the manufacturers. Most of the material is, therefore, available in the form of brochures directly from the vendor. As such, it would seem to be of limited value to clinical laboratories. This seems not to be the case. Many laboratory workers seem to agree that it is "nice to have all of this material in one place." Caution, nevertheless, should be exercised by the reader. The descriptions of most instruments can hardly be regarded as unbiased.

The second chapter consists of a brief review of "Basic mechanics and electricity." It is too short and superficial to be of value. There is a final chapter on data processing in which a computer system, the Clin LAB-12, is described. The fact that this system is no longer being developed is partly compensated by the fact that it resembles other systems which are under rapid development.

—FRANK C LARSON, MD

Vascular Surgery, Volume I: Peripheral Arterial Diseases

By John J Cranley, MD. Medical Department, Harper & Row, Hagerstown, MD, 1972. Pp 282. Price: $19.95

This new book on peripheral vascular surgery is a welcome addition to the field. The senior author and his contributors have eleven chapters including "Obliterative Arterial Disease of the Extremities," "Cerebral Vascular Insufficiencies," "Vascular Trauma," "Thoracic Aneurysms," and "Neuro-vascular Compression Syndromes" and "Renal-vascular Hypertension." Each chapter is very well subdivided and has an excellent bibliography. The authors candidly discuss both sides in opposing therapeutic situations including not only surgical but nonsurgical procedures. Their results, and results of others, are carefully evaluated. They draw heavily on their experiences, particularly in the section on "Obliterative Arterial Disease."

Excellent photographs of angiographic studies pre- and postoperatively complement drawings throughout the chapters. The details of the surgical techniques are not found in all instances, particularly with reference to the section on "Cerebral Vascular Disease" but there are adequate references to the surgical techniques in the bibliographies. The outstanding chapters included: "Obliterative Arterial Disease," "Cerebral Vascular Insufficiency," "Aneurysms of the Thoracic Aorta" and "Vascular Trauma."

This book is an excellent reference volume for any library or person interested in vascular disorders.

—GEORGE M KRONCKE, MD

Seeing and the Eye

By G Hugh Begbie. Doubleday & Company, Inc, New York, NY, 1973. Pp 227. Price: $2.95

This book on seeing and the eye is pleasant and easy to read. The author follows the standard format used by many others in the treatment of this subject. He starts out by a simple exposé of theories of light propagation, followed by the anatomy of the eye and the histology of the retina. Then he delves into sensory physiology and psychophysics, identifies problems of light and dark adaptation, spatial and temporal summation, and acuity. Lengthy chapters are devoted to color vision, and the relation of eye movements to perceptual distortions such as the waterfall illusion. The author makes an effort to give an explanation of these problems in terms of known physiological and anatomical mechanisms.

There is very little documentation which is excusable, because the book is not intended to be a source book. One wishes, however, there were not so many mistakes. The author relies heavily on centrifugal fibers to the retina to explain gain in receptor sensitivity during dark adaptation. This is wrong. Up to date centrifugal fibers to the retina have been demonstrated only in the pigeon eye. The current explanation of neural dark adaptation depends on the feedback circuitry within the retina for which plenty of anatomical evidence exists.

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BOOKSHELF . . .

The author comes to the conclusion that acuity is aided by eye movements. This view was popular in the 1940s and has been proven wrong in the 1960s. In summary, this book gives a taste of the problems in vision, but it is sadly out of date. —ULKER T KEESEY, MD

Bone Tumors
Fourth edition. By Louis Lichtenstein, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 440 pages. Price: $24.50

Dr. Lichtenstein is one of few individuals qualified to write with authority on bone tumors. He has made many primary contributions to the field of bone pathology. The text is admittedly pragmatic, but conflicting viewpoints are adequately presented.

The book is easy to read with many facts presented in a pleasant narrative fashion rather than in an outline form. Illustrations are numerous and clear. A large bibliography follows each chapter. In addition to the basic descriptive material, the book contains information on diagnosis and treatment. The material on diagnosis emphasizes the importance of an adequate biopsy and the necessity of considering clinical, radiographic, and histologic findings before reaching a diagnosis.

The Fourth Edition contains additional recent references, additional illustrations, and a new chapter on rare primary bone tumors. Adamantinoma of long bone is now called a dermal inclusion tumor.

The book remains a classic for those interested in pathology, radiology, and orthopedic surgery.
—ANDREW A. MCBEATH, MD □

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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oint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is) affirm the support of the participat- ng organizations for the laws, regula- ons and professional traditions which rohibit the unauthorized substitution f drug products.

Traditionally, physicians, den- sts and pharmacists have worked ooperatively to serve the best inter- sts of patients. Productive coopera- on has been achieved through nutual respect as well as a common oncern for the ideals of public ervice. This mutual respect has been eflected, in part, by joint support ver the years for the adoption and nforcement of laws and regulations pecifically prohibiting unauthorized ubstitution and encouraging joint iscussion and selection of the ource of supply of drug products. he basic principles of medical, den- al and pharmacy practice are thus tilized and preserved in the interest f patient welfare.

The antisubstitution laws have ot obstructed enhancement of the rofessional status of pharmacy any nore than they have in and of them- elves guaranteed absolute protec- ion from unsafe drugs, or freed hysicians, dentists and pharmacists rom their responsibilities to patients. s a practical matter, however, such aws and regulations encourage inter- rofessional communications regard- ng drug product selection and assure ach profession the opportunity to xercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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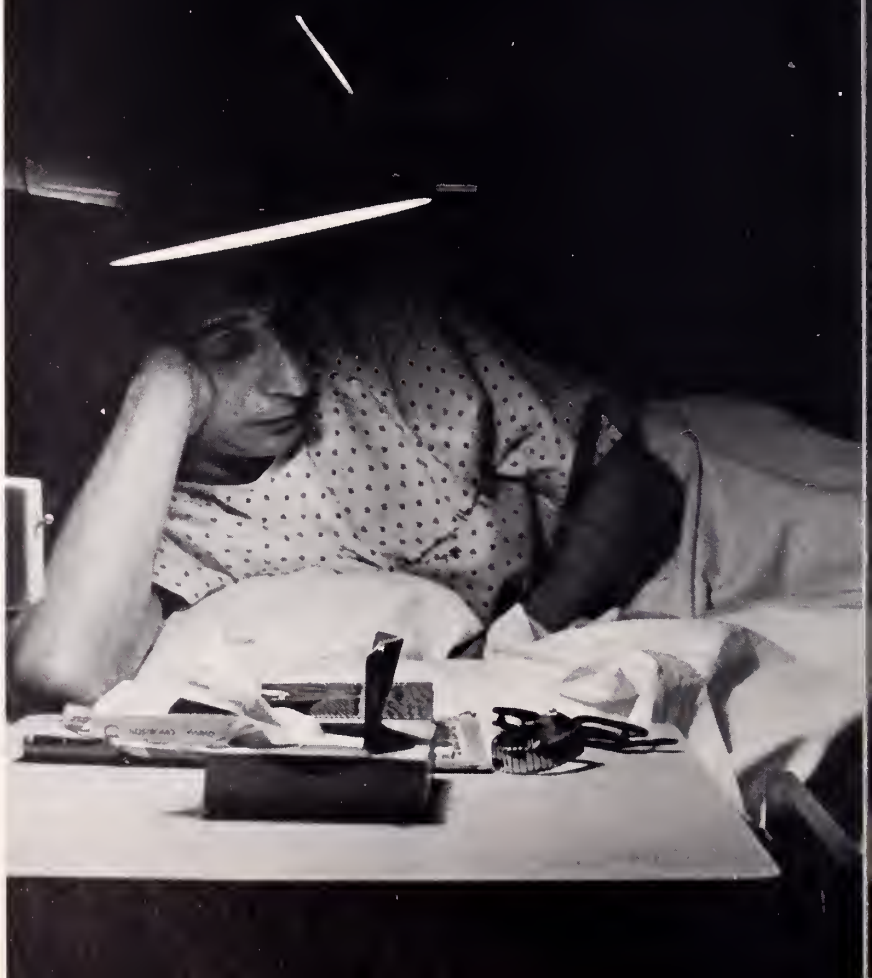
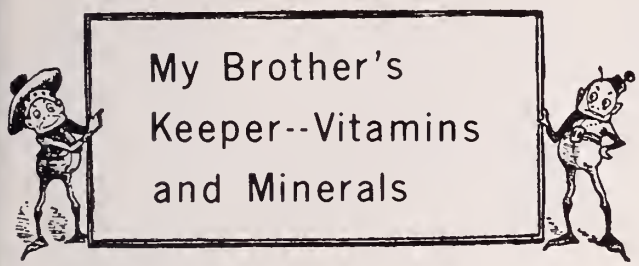


RAYMOND HEADLEE MD, Elm Grove—Editorial Director



In August of this year new definitions and restrictions were placed upon the sales of vitamins and minerals. This was done by the Food and Drug Administration, as part of its charge by the Congress of the United States to safeguard the public.

This change was accomplished despite considerable public pressure, the FDA alone processing over 20,000 complaints forwarded from congressmen, expressing concerns of their constituents. Many physicians are aware of the uproar, but for those who are not, or who were not fully aware of the range of the problem, some reflections follow.

First of all the FDA changed the old "minimal daily requirement" (so familiar to us cereal box readers) to "United States Recommended Daily Allowance known as *U.S. RDA*. These amounts are based on results of ongoing research especially by the National Academy of Science, and amounts are generally larger than the old minimal dosages.

Second, there is a clearer definition of the precise use of such figures. For example, any product supplemented with up to 50% of the vitamins and minerals needed to maintain health (U.S. RDA) are designated general foods. When supplementation is from 50% to 150% of the U.S. RDA, the product so supplemented must be considered, and presented as dietary supplement. These products are used by well and healthy individuals seeking some insurance, say against faulty eating habits or faulty food; in no way may these amounts of vitamins and minerals be presented as useful in treatment of any disease or medical condition.

Lastly, any product containing more than 150% of U.S. RDA must be considered a drug. It's as simple as that. This does not mean that such heavy doses of vitamins and/or minerals are necessarily efficient in the treatment of disease, nor that their availability would therefore be only by prescription from physicians. After all aspirin, for example, is classed as a drug, and is widely and freely available.

There are several points of interest to the physician in this latest FDA action. It is an accurate description of the sort of illogic that I've been expounding in these editorials over the past four months. We cannot afford to sneer or even to laugh at a public reaction such as occurred about this FDA activity. It might be tempting to call it stupid, that the use of the federally defined term drug should cause any outcry. Why, aren't we fully aware that the term drug does not change the vitamin, or the mineral! Besides, the product is still available to the public so whatever is the matter with their thinking? Well, maybe that is correct, and the correct approach. I think not. It seems we must allow for faulty logic and specious thinking, not to agree with it but to not be startled by it, nor hostily offended. To do so, as with other illogics, merely hardens the resistance. Defenders of their . . . (medical) . . . freedoms will hear our outraged explosion as further proof that doctors are greedy and only wish to control all things health-wise (not only when asked). Here, as with the fluoride examples, the facts do not matter. The designation of drug to some substance previously thought to be natural, free, and healthy was sufficient to set off some sort of storm.

Another facet of this decision, of which physicians may not be fully aware, is the scientific basis of the change. When I was in medical school, in the 1940s, it was generally thought that vitamins and minerals were such innocuous substances that excessive quantities would merely be excreted. I can recall my saying those very words hundreds of time. Now they tell us this is not so. Excessive Vitamin A intake can cause pressures within the brain similar to the pressures caused by brain tumors. Excessive and prolonged doses of Vitamin D can cause calcification in soft tissues and bone deformity in adults as well as in children. And so on goes the list. What once seemed so safe is not so safe. Has our brother kept us well or are we to believe our freedoms are being abridged, as the 20,000 congress writers, and the many more who thought but did not write seem to have interpreted it.

A last point of interest to physicians might be that in spite of the clear work of the FDA noted above, there was enough public pressure to the contrary to warrant the activity of a "National Health Federation." It is hard to know whether the Federation came first, or the surgent public need formed the Federation, or even whether the Federation already existed and hitched itself to an available issue. At any rate note that the Federation, in regard to the FDA actions described, did organize a broad national campaign against the regulations noted above, with these four bits of misinformation leading the list:

—That up to 80% of all health food stores and other dealers in the vitamin-mineral business will be destroyed.

—That important vitamin-mineral products will be taken away from the general public.

—That other important vitamin-mineral preparations will be made more difficult to obtain—and more expensive—by restriction to prescription only.

—That FDA is interfering with the individual's freedom to eat what he chooses and to supplement his diet as he sees fit. —RH □

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

A Plea to Surgeons/ by GARY A. BECKER, MD, *Medical Director*

Badger Regional Red Cross Blood Center, Madison, Wisconsin

SINCE THE MAJORITY of blood and blood components transfused in this state is given in operating rooms, habits and idiosyncrasies of individual surgeons can have a profound effect on the operation of hospital blood banks and regional blood supplies. Wisconsin, with its system of regional centers providing voluntarily donated blood, is the envy of many states. Community blood centers came of age with development of the Milwaukee Blood Center. The Badger Red Cross Regional Blood Center has been committed to the total supply of its many hospitals for over twenty years. What are the biggest problems faced by regional blood centers? Maintaining adequate blood supply and distributing it appropriately head the list. It is in the latter area where surgeons have great influence.

Many hospitals, distant from their regional supplies, receive blood weekly or biweekly. Blood bank directors attempt to stock a safe and adequate supply. However, excessive stocking of blood leads to shortages elsewhere and eventually to outdating. The most common reasons for keeping excessive amounts of blood in hospitals are: very short notice of elective surgery and orders to cross-match for surgery many units of blood, which usually are not used. Physicians in all surgical specialties can help blood banks if they will do the following:

(1) Send a blood sample from the patients who will have elective surgery to the blood bank at least three days (and preferably one week) prior to admission. By knowing the patient's blood group and type, the blood bank can order from its regional supplier accordingly.

(2) Review blood usage in the operating room regularly to determine if the amount of blood cross-matched can be decreased.

(3) Release blood from cross-match as soon after surgery as possible.

(4) Consider ordering only a blood group, type and antibody screening on patients undergoing surgery which rarely requires blood. If blood is needed it can be cross-matched (in the absence of unexpected red cell antibodies) within thirty minutes. This saves the patient money and allows the blood bank to work more efficiently with a smaller total inventory.

Surgeons in this state, for the most part, have cooperated very well with our program of component therapy by using packed red cells in place of whole blood. If they will seriously consider the above suggestions, more efficient blood banking services will be available to all hospitals and all patients in Wisconsin.

fotos/74

STATE MEDICAL SOCIETY PHOTOGRAPHY CONTEST

OPEN TO ALL MEMBERS OF THE STATE MEDICAL SOCIETY

Contest rules have been simplified to make it easier to enter your photographs.

All photographs entered should be mounted in the form in which entrant would like his prints to be exhibited. Mounted pieces should not exceed 16 inches by 20 inches. No frames will be accepted.

Prize winning photographs, if received unmounted will be mounted on 16x20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

A maximum of 10 prints may be entered by each entrant. All entries must be at the State Medical Society headquarters in Madison by March 1, 1974. Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Servic

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbid and Mortality Weekly Report*, the Adv ory Committee on Immunization Pr tices of the United States Public Hea Service presented recommendations the use of combination live virus vaccin The committee stated that:

- "Data indicate that antibody respon to each component of these combinati vaccines is comparable with antibody sponse to the individual vaccines giv separately.
- "There is no evidence that a verse reactions to the combin products occur more fr quently or are more seve than known reactions to t individual vaccines (see p tinent ACIP recommend tions).
- "The obvious convenien of giving already select antigens in combined fo should encourage consider tion of using these produ when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

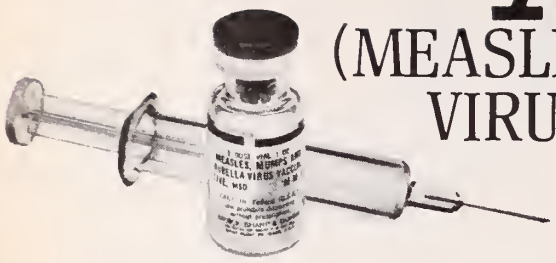
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give *intravenously*. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1–9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

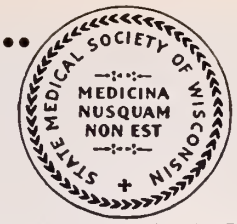
Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

SECTION



OPHTHALMOLOGY

DECEMBER 1973

EDITOR: Thomas M. Aaberg, MD, Milwaukee

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THANK YOU, DOCTOR ALLEN

The Section on Ophthalmology of the State Medical Society of Wisconsin is indebted to Dr. James Allen of the Ophthalmology Department, University of Wisconsin, for the five years of service as editor of this Ophthalmology Page. He has kept the ophthalmologists of the State of Wisconsin informed of happenings within the state's political and academic realm for these many years. It is with trepidation that future editors will attempt to fullfill the same role.

It is hoped that all persons with information, political or academic, will forward such information to the present editor:

Thomas M. Aaberg, MD
Medical College of Wisconsin
8700 West Wisconsin Avenue
Milwaukee, Wisconsin 53233

It is furthermore requested that short original articles of scientific or academic interest, limited to 3.5 double-spaced typewritten pages, be forwarded to the editor. Hopefully, on an every other issue basis, such scientific articles can be published. By necessity such short articles will be of different nature than might be submitted to major journals; i.e., surgical techniques of interest to fellow colleagues, information which might update current concepts, or talks which have been given to various organizations that might be of interest to the state members at large.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

Dr. Paul H. Goldstein, Secretary of the Milwaukee Ophthalmological Society, extends an open invitation in behalf of the Society to all state ophthalmologists and their guests to attend the following monthly meetings in 1974: January 22 (Dr. Robert Burns—speaker); February 26 (speaker to be announced); March 26, night of the State Medical Society, Ophthalmology Section, meeting (Dr. Phillips Thygeson—speaker); April 23 (Dr. John Henderson—speaker). All meetings are dinner meetings at the University Club, Milwaukee, beginning at 6:00 PM. Anyone wishing further information should contact Dr. Paul H. Goldstein, 2040 West Wisconsin Ave., Milwaukee, Wis. 53233.

STATE MEDICAL SOCIETY, OPHTHALMOLOGY SECTION

Tabulation of the questionnaire sent to the Section on Ophthalmology by Dr. Samuel Blankstein should be of interest to all ophthalmologists. The replies will be reported by questions as they were asked.

1. Do you agree that optometry should be deleted from any health insurance program sold by WPS?

   Yes **56** No **15**

2. Do you agree that there should be no compromise on this principle?

   Yes **51** No **16**

3. Will you agree to help the Committee take firm action if our requests are not met? We are referring to taking all steps possible within the Medical Society to have WPS delete optometric coverage.

   Yes **55** No **11**

4. Do you think we need a part-time executive secretary of our Section to coordinate and follow up on important legislation that optometry is trying to introduce into the State Legislature; namely, (a) the use of drugs, (b) consider optometrists as physicians in any health insurance policy being sold in this state.

   Yes **59** No **11**

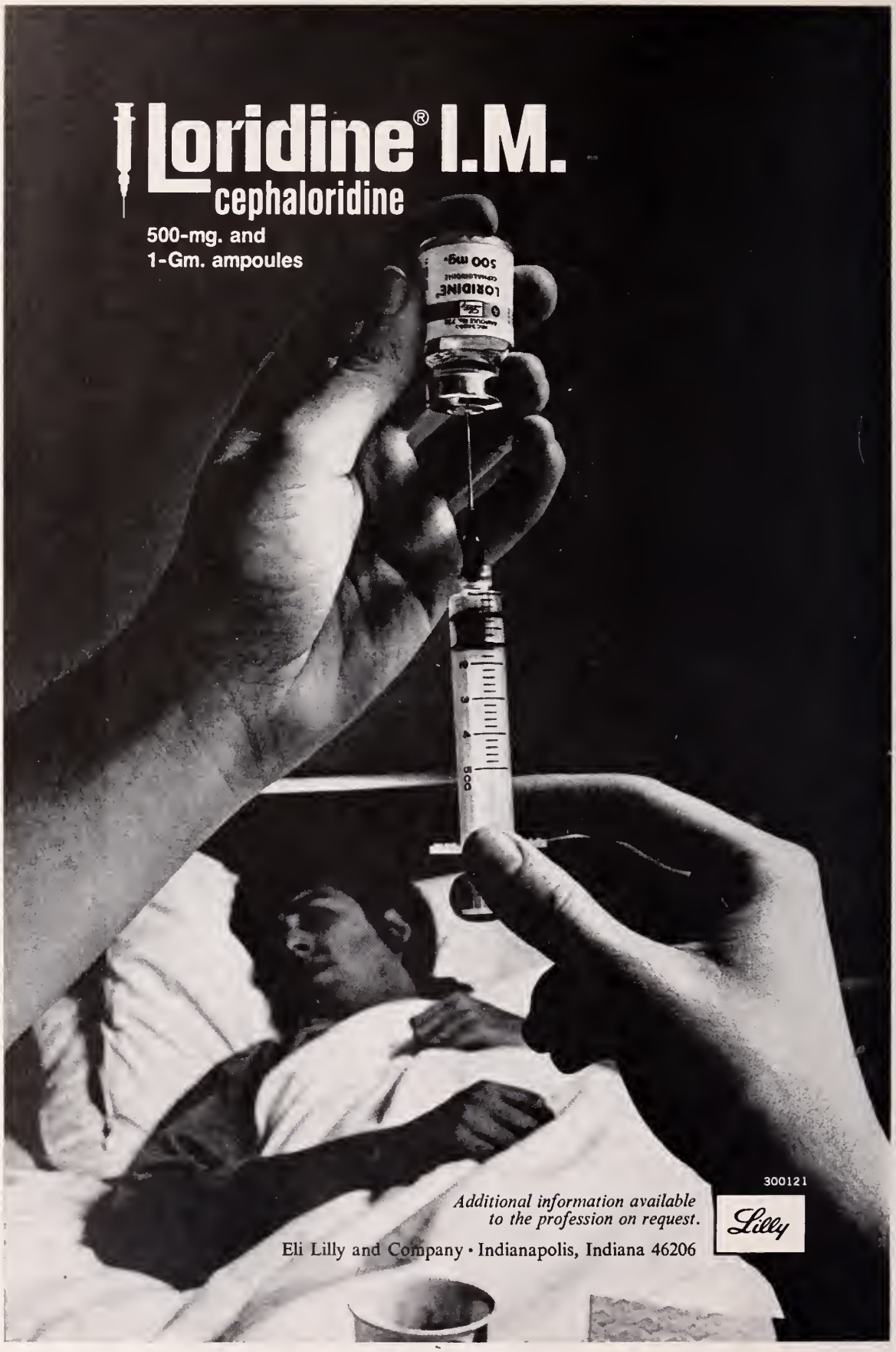
5. Will you contribute to a voluntary yearly assessment of $100.00 to finance these efforts, as many have done in the past?

   Yes **52** No **13**

6. Will you work in your area to contact Senators and Representatives as well as your representatives to the State Medical Society?

   Yes **58** No **8**

Total replies were 73. Any combination of Yes and No answers that do not add up to 73, consisted of lack of answers to specific questions or answers with reservations. Every question had many written qualifications. The above information is being reported at the request of Mr. H. B. Maroney, Assistant Secretary of the State Medical Society, and at the suggestion of Dr. James C. Allen. □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WISCONSIN MEDICAL JOURNAL VOL. 72, NO. 12 DECEMBER 1973

Abdominal Aortic Aneurysm Resections— Late Complications

SADAO KASAI, MD
ROBERT J. BECKES, MD
KENDALL E. SAUTER, MD
Milwaukee, Wisconsin

JOSEPH M. KING
Festschrift

PART II

Because of the tremendous response to the call for scientific papers and tributes and because of the economical necessity to limit the number of pages per issue, the Editorial Board has found it necessary to present the Joseph M. King Festschrift in two issues: November and December 1973. The Board further acknowledges its regrets that not all of the material submitted could be included. The Editorial Board wishes to commend with deep appreciation the assistance of Dr. Leonard Worman in coordinating these issues.

In 1952 DUBOST et al[1] first reported the successful resection of an abdominal aneurysm and replacement with a homograft. Time revealed that homografts disintegrated and these were replaced with synthetic materials. Since adoption of this material, long-term survival after grafting has been rewarding. Nonetheless, complications have been reported. These may occur years after successful grafting. Complications reported late have been listed as thrombosis, disruption, false aneurysm, and aorto-enteric fistulas.

Three cases with complications 11, 9, and 6 years later recently have been seen and are reported here. The first, 11 years after resection, was a false aneurysm. The second, 9 years following surgery, was a ruptured hypogastric aneurysm below the previous resection. The third was a ruptured aorto-enteric fistula which occurred 6 years following resection.

Case Reports

Case 1. This was a 70-year-old Caucasian male admitted with a pulsating abdominal mass. Aortic aneurysm grafting had been performed 11 years earlier (1961). The aneurysm was 7 cm in width and 10 cm in length. A Dacron sleeve was placed and sutured with 0-0-0 silk. The postoperative course was uneventful. Five years later he complained of left-sided abdominal pain, but retrograde aortograms demonstrated no aneurysm. After another three years a physical examination revealed increased pulsation of the abdominal aorta. Aortograms again were normal.

Eleven years after surgery the patient presented with a large pulsating mass in the left side of the abdomen, accompanied by abdominal pain. The mass extended from the mid-abdomen to the left upper quadrant. An intravenous pyelogram and upper gastrointestinal series demonstrated an abdominal mass and obliteration of the psoas shadow. The left kidney was displaced cephalad and laterally. The left ureter was displaced laterally.

At operation, nine days after admittance, a saccular aneurysm was found to arise from the previous graft area. It displaced the duodenum to the right and cephalad. The left ureter was found attached firmly to the posterior lateral side of the aneurysmal wall. The wall of the aneurysm was densely fibrous with no mural calcification. On opening the sac, the distal 7 cm of the anterior wall of the previous Dacron graft was seen lying free in the aneurysmal sac with the free opening distally. No suture materials were seen at its free end. The openings of both common iliac arteries also were seen in the bottom of the aneurysmal sac. A bifurcated knitted Dacron graft was placed from the distal end of the previous graft to both common femoral arteries.

The surgery was complicated by a small perforation in the fourth portion of the duodenum where it was

From the Surgical Service, St. Joseph's Hospital, Milwaukee, Wisconsin.
Reprint requests to: Kendall E. Sauter, MD, 2442 North Harding Blvd., Wauwatosa, Wis. 53226.
Copyright 1973 by the State Medical Society of Wisconsin.

adherent to the aneurysmal wall. This was closed. His postoperative course was uneventful, and he was discharged on the 13th postoperative day.

Case 2. A 76-year-old Caucasian male was admitted to the hospital emergency room in shock with severe abdominal, back, and right hip pain. History revealed resection of an abdominal aneurysm in 1964, nine years previously. He also was known to have auricular fibrillation secondary to arteriosclerotic heart disease and was taking digitalis.

After initial resuscitation, he was taken to the operating room where cardiac standstill occurred. The heart was started, following which the abdomen was rapidly entered. Massive hemoperitoneum was present. A large ruptured hypogastric artery aneurysm was found and clamped. The aneurysm was then closed from the internal aspect, proximally and distally. The previous graft was intact, the external and common iliac were preserved and pulsated normally.

The patient received eleven (11) units of blood in the operating room and six (6) later. He recovered satisfactorily with some cardiac and respiratory manipulation and gradually stabilized. Urinary output was good for the first five days, then gradually decreased to 50 ml per day with elevation of the creatinine and blood urea nitrogen, at which time renal dialysis was instituted. After five weeks the patient was discharged wih normal urinary output. The creatinine clearance, however, remained low.

Case 3. A 57-year-old white male entered the hospital with gastrointestinal bleeding. Six years before (1966) a Dacron sleeve graft had been placed utilizing a 3-0 Tevdig suture for the anastomosis. At that time the graft was not reinforced with aneurysmal tissue because of lack of sufficient aortic wall. The retroperitoneal tissues were closed creating a barrier between the graft and the second part of the duodenum. The postoperative course was uneventful. Since that time the patient had had surgery for bowel obstruction in 1968, left carotid endarterectomy in 1970, and for recurrent bowel obstruction in 1972.

At the last admission he complained of lower left quadrant pain and tarry stools. Massive uncontrolled hematemesis and melena occurred, with unconsciousness and death shortly thereafter. Autopsy revealed erosion of the upper portion of the graft into the small intestine, 27 cm distal to the pylorus.

Discussion

Occurrence of false aneurysms at the site of anastomoses has been described by many authors.[2,3,4,5,6] The incidence in any location has been variously reported as 0.8% to 15%.[7] Common sites of occurrence are at an active joint or at an end-to-side anastomosis.[8,9] In Case 1 the false aneurysm was found to be at the distal end of the prosthesis over the lower lumbar vertebrae. The anastomosis was end-to-end. The prosthesis used was knitted Dacron.

The importance of the porosity of the prosthesis was first emphasized by Blakemore and Voorhees[10] from their observation in the laboratory. The coagulum formed in the inner surface and the interstices of the prostheses immediately after placement is replaced with connective tissue. The pseudo-intima thus formed has been demonstrated by many authors. Occurrence of late thrombosis of a prosthesis arouses suspicion of failure of the pseudo-intima, (flap formation) infection, kinking, and distal obstruction.[11]

Dacron prostheses have been shown to have an absence of toxicity, allergic potential, and durability for prolonged implantation. Knitted Dacron prostheses have higher porosity and more secure pseudo-intima. The suture material used in our case 11 years prior was silk. Silk as the suture material has been shown to disintegrate,[12] and loses its tensile strength with time.[13] Stoney et al,[8] in their experience with silk sutures, however, attribute the suture line failure to the host artery adjacent to the suture line as a major cause of failure. Cohn and Angell[5] reported eleven (11) cases, of which three (3) had false aneurysms. They suggest the possible occurrence of a new aneurysm at the site of aortic cross clamping.

In an extensive study of Dacron arterial substitute by Szilagyi et al,[14] healing at suture lines between implant and artery takes place through a process roughly similar to the sealing of interstices of the fabric. The suture line is closed by a fibrin layer which soon is replaced by connective tissue. True intima does not extend from the arterial side into the prostheses for a distance greater than a few millimeters.

Since tensile strength of the connective tissue bridge on the outside of the suture line is of a low order, the integrity of the anastomotic line will depend largely upon the strength of the suture itself. At the present time the predominant suture advisable is of a synthetic type.

In making the diagnosis of a recurring aneurysm in the abdominal cavity, history of previous operation to the aorta, palpation of a pulsating mass, radiologic demonstration of a density (soft tissue mass with or without linear calcification and filling defect) were emphasized by Nevin.[3] In Case 1 three series of aortograms (retrograde and brachial aortography) failed to demonstrate the false aneurysm, while the physical examination and intravenous pyelogram eventually demonstrated it. The wall of this false aneurysm did not contain calcium.

We can only assume that a false aneurysm might have been developing in the preceding years in this case. If the aneurysm sac is filled with clots, its demonstration by aortography is impossible. No pleating and/or wrinkling (non-corporation)[14] were shown, whereas a tortuosity was seen on the aortograms. Fortunately the large false aneurysm of our case did not rupture. Many false aneurysms have been reported to rupture either into the free abdominal cavity or into the intestine.[4,5,15] False aneurysms arising adjacent to the duodenum often lead to aorto-enteric fistulas, probably due to compression necrosis of the intestinal wall and digestion of the wall of the aneurysm by digestive enzymes from the gastrointestinal tract.

Treatment for the false aneurysm should consist of immediate operation.[11] We successfully placed a knitted bifurcation graft from the distal end of the previous graft to the common femoral arteries. In this case, the cause of failure was probably dissolution of the silk suture.

Several cases of successful treatment of aortoenteric fistulas have been reported in the literature.[16] The usual practice at the time of initial aneurysmectomy has been interposition of a portion of the aneurysm wall between the graft and the duodenum. Occasionally when sufficient aortic wall is not available a pedicled omental graft may be interposed between the vascular suture line and the duodenum. Incision of retroperitoneal tissues should be made in accordance with the necessity for its closure and interposition between the graft and the duodenum.

Frequently gastrointestinal bleeding of several days standing will precede actual rupture and fistula formation. Treatment is best described as preventative. Grafts which are too long and bow anteriorly are difficult to cover with viable tissue and predispose to fistula formation.[17] Treatment consists of resection of graft and closure of the bowel. If distal ischemia is present, extra abdominal bypass is necessary. Antibiotics by irrigation, locally and systemically, may be helpful. Some authors[18] recommend en bloc resection of bowel and prosthesis with insertion of a new prosthesis.

As vascular disease is a generalized process, it is not surprising to find renal stenosis and aneurysm, carotid insufficiency and aneurysm, myocardial insufficiency, and peripheral vascular disease in patients who have had resected abdominal aneurysms. The co-existence of femoral, iliac, and popliteal aneurysm is well known.

Case 2 revealed a ruptured hypogastric artery aneurysm rather than a ruptured graft. The symptoms and signs at the time of rupture were shock, back pain with radiation into the right leg, indistinguishable from those of rupture of the previous graft. This case reinforces the rewards of vigorous attempts in spite of what would appear to be a hopeless situation.

Summary

Three cases of late complications after abdominal aneurysm resection are reported. In the first case diagnosis was made on physical signs, intravenous pyelogram, and upper gastrointestinal series. Resection of the false aneurysm and reanastomosis to bifurcation graft was successfully completed. The second was diagnosed at laparotomy, and the third defied emergency treatment.

JOSEPH M. KING, *Festchrift*

WISCONSIN MEDICAL JOURNAL
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"Gruff Yet Tender"

The years have "slipped by" like a gust of wind and one wonders—what have I done with my life? Probably the individuals who can answer that question most assuredly are those who were your students and disciples in the field of surgery.

The hours and days you have given in active surgery, in direct supervision of your residents and students and in administrative functions are innumerable.

How does one measure your "gust of wind" of a lifetime in surgery?

Look around you, Doctor King. Look around you! You will see your craft and art, your compassion for the ill and maimed, being administered *in your way*—the "gruff yet tender" understanding that deals with either the most severe or the most minute surgical problem in a resolute, honest and forthright manner—through all your residents. Your way has been allowed to grow, to be expanded upon and reproduced in further generations. There it is, the truthfulness with the patient who needs to know the truth, no matter how bad or catastrophic the effect upon his life. He must be cared for the proper way, with honesty.

Surgical knowledge and techniques and scientific advancements can be taught by many but *only a few* can affect the personality of the resident. That, Doctor King, is what you have done to all of us who served under you. The gust of wind is now a constant swirl of activity within the surgical arm that abounds throughout the Midwest, the country and the world. Your strength and your honor will be upheld in all surgical spheres.

Only one person has been unchanged and she is the one who has shared all of your trials and tribulations, suffered your pain and rejoiced in your accomplishments. Yet she alone is probably the envious one in your life for if she could not have been your wife, I am sure that she would have wanted to be one of your surgical residents, as I had the distinct pleasure of being.

—John D. Riesch, MD, Menomonee Falls

These cases illustrate the need for closer attention to the symptoms of abdominal pain, pulsatile mass, and gastrointestinal bleeding in patients who have had a past history of aneurysm resection and replacement with a synthetic graft.

It is hoped that a review of these cases will serve to illustrate the necessity for follow-up of resected cases, the extreme variability of complications, and the worthwhile results which can be achieved with aggressive therapy.

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Tributes

Excerpts from a collection of letters

JOSEPH M. KING, *Festchrift*

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"Over the years that I have practiced here in Racine there have been many occasions that arose and that I was able to handle only because of my training at County. Your teaching and your ability to discipline us in such a kind way are attributes I have admired all these years."

—William J. Madden, MD, Racine

"I think we all want you to feel that your many years of fine service to the University and the Milwaukee County General Hospital did not go without appreciation by us all. Moreover, your constant tendency to extend yourself, to go beyond that which was just plain necessary, and your understanding of the students, what has made you the fine teacher that you are. In addition to all of these things, there is also that undefinable, intangible factor which makes for a great teacher, with which you are so richly endowed. With you having been our mentor for all these years, we can truly say that 'we owe one man so much.'"

—Gerald R. Zupnik, MD, Milwaukee

"Your picture, autographed 'my first senior resident,' hangs in my office next to familiar photographs of the Milwaukee County Hospital and the first televised operative procedure in Wisconsin. Since I have occasion to glance at these pictures almost daily in my surgical practice, they are a clear reminder of what you have meant to me, to your numerous surgical residents, and to Milwaukee medicine."

—Joseph J. Gramling, MD, Wauwatosa

"I have never known anyone with such a memory for names, faces and incidents. I recall you walking down the wards at the County Hospital and calling each patient by name. You were the same with all the students. To you every one was a real person, an individual worth noticing and such things as status, race, creed and color were of no concern to you. Let me summarize by saying that anyone who had worked under 'Joe' King was certain to be a better physician and better man for the experience."

—George Parke, MD, Richland Center

Cadaver Kidneys Are a Wasted Community Resource

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JOSEPH M. KING
Festschrift
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CADAVER DONORS CONTINUE to constitute the largest single source of organs for kidney homotransplantation.[1] Of 94 transplants performed at the Milwaukee County General Hospital, 60 (64%) have come from cadaver donors. While there have been increasing numbers of cadaver kidneys available, the demand both locally[2] and nationally[3,4] is clearly outdistancing the supply. This is discouraging to physicians caring for patients with end-stage renal disease because the quality of life with a good functioning transplant far exceeds that of dialysis. What is more discouraging is conservative data of Fox et al[5] which indicates that the number of potential cadaver donors is more than adequate to meet the demand.

This article will document that the transplant program at The Medical College of Wisconsin and Milwaukee County General Hospital is a community resource serving the needs of patients in both government and private community hospitals; that the quality of this program is clearly adequate; that the transplant team has and is prepared to go to any hospital at any time to procure cadaver kidneys; and that the number of potential cadaver kidneys available in community hospitals in Milwaukee County is by no means being realized.

Past Transplant Activities

In the past 5 3/4 years the Southeastern Wisconsin Transplant Program has performed 94 transplants (Table 1). Thirty-four of these patients have come from Medical School hospitals (Milwaukee County General Hospital and Wood Veterans Administration Hospital) and the other 60 patients (64%) have been patients from private community hospitals. In the cadaveric recipient group, 23 of 60 patients were from Milwaukee County General Hospital or Wood Veterans Administration Hospital while 37 (62%) were from private community hospitals.

TABLE 1—*Dialysis hospital of transplant recipients*

Dialysis Center	Recipients	Live Donor	Cadaver
Milwaukee County General	19	6	13
Wood—Veterans Administration	15	5	10
Deaconess	21	2	19
St. Luke's	17	13	4
St. Michael's	7	4	3
St. Luke's (Racine)	5	1	4
University of Wisconsin (Madison)	4		4
Marshfield Clinic	2	1	1
Lutheran (La Crosse)	1	1	
Theda Clark (Neenah)	1		1
Stevens Point	1		1
St. Joseph's	1	1	
Total	94	34	60

Not only do the majority of recipients come from private community hospitals but also the largest number of total transplants and cadaver transplants performed from any given dialysis unit has been that from Deaconess Hospital in Milwaukee (Table 1). The willingness of the transplant program to serve the needs of any dialysis program is further demonstrated by the fact that patients from 12 separate dialysis programs throughout Wisconsin have been transplanted (Table 1).

Patient Selection

The first two cadaver transplants at Milwaukee County General Hospital were performed before tissue typing was available either locally or nationally. The next 10 patients had tissue typing performed prospectively (living related donors) or retrospectively (cadaver donors) by Dr. Paul Terasaki at the University of California at Los Angeles. Patient number 13 was typed prospectively by Dr. Donald Kuban, St. Luke's Hospital, Milwaukee, and by Dr. Terasaki. Since that time all cadaver donors have been typed by Dr. Kuban.

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TABLE 2—*Transplant survival*

	All Patients	> 12 Months
Total transplants	94	66
Total patients transplanted	83 *	59 **
Patients alive	62 (75%)	41 (70%)
Patients alive with functioning kidney transplant	52 (63%)	38 (66%)

* 11 second transplants
** 6 second transplants

TABLE 3—*Living related donor transplant survival*

	All Patients	> 12 Months
Total transplants	34	21
Total patients	33 *	21
Patients alive	27 (82%)	18 (86%)
Patients alive with functioning kidney transplant	23 (70%)	17 (81%)

* 1 second transplant

TABLE 4—*Cadaver transplant survival*

	All Patients	> 12 Months
Total transplants	60	44
Total patients	50 *	39 **
Patients alive	35 (70%)	23 (59%)
Patients alive with functioning kidney transplant	29 (58%)	21 (56%)

* 10 second transplants
** 5 second transplants

TABLE 5—*Cause of death—21 patients*

Sepsis (bacterial, viral, fungal)	9	(43%)
Myocardial infarction and/or arrhythmia	5 *	
Hemorrhagic diathesis	2	
Cerebrovascular accident	2	
Subarachnoid hemorrhage	1 *	
Internal carotid occlusion	1	
Pulmonary embolism	1	
Fulminant hepatic failure	1	
Hypertensive encephalopathy	1	

* 2 deaths on stable dialysis after loss of graft

Patient selection, for cadaveric kidney transplants, is made exclusively on the basis of tissue typing results. With only one pair of cadaver kidneys have there been more than two patients with comparable matching, and in this instance secondary considerations were made in patient selection. Thus, the use of typing data as criteria for cadaveric recipient selection avoids any stigmata of patient, or dialysis unit, preference by the transplant team. The fact that this method of patient selection is unbiased is substantiated by the fact that 62% of cadaveric recipients have come from 10 separate community hospital programs (Table 1).

Patient and Transplant Survival

A total of 94 transplants have been performed in 83 patients (Table 2) with 11 patients receiving a second transplant after losing their primary graft, usually from rejection. The overall survival rate is 75% and the 12-month survival rate is 70% (Table 2). Survival rates for recipients of living related donors (Table 3) is slightly better with an 82% overall survival and an 86% survival of patients over one year. Survival rates of cadaveric recipients are somewhat less (Table 4) with an overall survival of 70% and a 12-month survival of 59%.

The number of patients surviving with functioning transplants, in each category (Tables 2, 3, 4), is slightly less than that of total patients surviving. This reflects a policy whereby when inexhorable rejection occurs the transplant is removed and the patient is returned to dialysis. Twenty-one patients have lost their original transplant and are currently on dialysis or have been retransplanted. Rejection (16 patients) was the most common cause of graft loss while in three patients it was due to technical factors. One patient lost his graft from recurrent glomerulonephritis and one patient thrombosed her renal artery, A-V fistula and an intracerebral vessel simultaneously from profound congestive heart failure from viral myocarditis.

Eleven of these 21 patients have been retransplanted with seven patients (64%) being alive and well with functioning second transplants. Eight patients are alive on return to dialysis and seven strongly desire a second transplant. Two patients died on return to dialysis; one from a subarachnoid hemorrhage from a berry aneurysm and the other 56-year-old patient had a cardiac arrhythmia and suspected myocardial infarction. Therefore, rejection of a transplant does not invoke an aura of hopelessness in patients; most look forward to a second transplant.

Causes of Death

The cause of death in 21 patients is shown in Table 5. Sepsis from opportunistic viruses, bacteria and fungi were responsible for 43% of deaths. The fact that steroids can completely mask conventional signs and symptoms of sepsis is exemplified by the fact that two patients died of idiopathic bowel perforations long after their surgery, with no clinical signs of peritonitis. Five patients died from either a myocardial infarction and/or arrhythmia. One of these patients was a stable dialysis patient who lost his graft for technical reasons and the other had been discharged with good transplant function. The remaining three patients with cardiac deaths died in the immediate post-transplant period. Seven other patients died from a variety of causes as shown in Table 5.

Efforts for Cadaver Kidney Procurement

A total of 92 kidneys have been procured from cadaver donors. Thirty-four of these kidneys have come from Medical College of Wisconsin hospitals while 58 (63%) have come from community hospitals or distant transplant centers (Table 6). The willingness of transplant physicians to go to any hospital, at any time, to procure cadaver kidneys is demonstrated by the fact that kidneys have been obtained from 15 different community hospitals

(Table 7). Sixty of these 92 kidneys have been transplanted in Wisconsin recipients and 32 have been shipped to other transplant centers. A high percentage of shipped kidneys have been blood group B or AB in which there were no suitable recipients in dialysis patients in Southeastern Wisconsin. Sixteen of the 32 shipped kidneys have been sent to either Madison, La Crosse, or Chicago—an attempt to utilize kidneys on a regional basis.

Although more kidneys have been shipped (32) than have been received (11) from distant transplant centers, most centers that have received kidneys from our program have reciprocated within a 6 to 12 month period. Highly satisfactory function rates of shipped kidneys have previously been demonstrated.[6] A kidney received from California on Jan. 11, 1970 has functioned excellently for 44 months, and the recipient has been a productive individual during that period. A second kidney from California underwent a total of 69 hours of preservation and functioned satisfactorily in a 7-year-old boy[6] and has continued to function well for 16 months.

Available Cadaver Donors in Milwaukee County

The data of Fox et al,[5] using strict donor criteria and allowing for time for logistical steps in obtaining cadaver kidneys indicated that in Milwaukee County hospitals there are 60 suitable donors (yielding 120 kidneys) per year. In reality, only 45 cadaver kidneys have been realized from Milwaukee County hospitals in the past 5 3/4 years—approximately eight kidneys per year or 7% of the available kidneys. Tables 6 and 7 clearly document that community hospitals outside of Milwaukee County contribute to the cadaver donor program three times as much as do the community hospitals of Milwaukee County. Table 6 shows cadaver kidneys[11] obtained in Milwaukee County is only equal to the number flown in from distant transplant centers.

Donor Availability in Southeastern Wisconsin

Calculations from extrapolations of the data of Fox[5] are shown in Table 8. If a procurement rate of only 50% of available donors in Southeastern Wisconsin were realized, a total of 120 kidneys per year would be available. Since blood group and tissue typing considerations cause only two-thirds of procured kidneys to be transplanted locally, this would reduce the number of available kidneys to 80. Since the other one-third of kidneys would be shipped to other transplant centers and since we currently receive approximately one kidney for each two we ship, an additional 20 kidneys would be available making the total number of available kidneys per year in southeastern Wisconsin 100. Since the maximum number of needed kidneys in Southeastern Wisconsin is 75 (Table 8), the supply of cadaver kidneys is fully capable of meeting the demand.

TABLE 6—*Sources of cadaver kidneys*

Medical College of Wisconsin Hospitals	
Milwaukee County General Hospital	30
Wood Veterans Administration Hospital	4
Distant Transplant Centers	11
Community Hospitals, Milwaukee County	11
Community Hospitals outside Milwaukee County	36
Total	92

TABLE 7—*Sources of cadaver kidneys transplanted at Milwaukee County General Hospital or shipped to other transplant centers*

Milwaukee County General	30
Distant Transplant Centers	11
Theda Clark (Neenah) / St. Elizabeth's (Appleton)	9
Waukesha Memorial	7
Elmbrook Memorial	6
St. Luke's and St. Mary's (Racine)	5
Wood—Veterans Administration	4
St. Luke's	4
Oconomowoc Memorial	3
Holy Family (Manitowoc)	3
St. Joseph's	2
Deaconess	2
St. Mary's	1
St. Michael's	1
Columbia	1
Hartford Memorial	1
Swedish-American (Rockford, Ill.)	1
University of Wisconsin (Madison)	1
Total	92

TABLE 8

	Milwaukee County	Southeastern Wisconsin
Suitable donors/year	60	120
Suitable kidneys/year	120	240
50% Procurement rate	60	120
2/3 Transplanted	40	80
1/3 Shipped	20	40
50% Shipped—received ratio	10	20
Total Kidneys Available	50	100
Needed Kidneys	75	

Speculated Reasons for Not Procuring Cadaver Kidneys

Since the above data clearly indicates a discrepancy in the cadaver kidney procurement rate between Wisconsin community hospitals in Milwaukee County and outside Milwaukee County, an analysis of the possible factors contributing to this discrepancy seems indicated.

I. Physicians are not aware of the needs of the transplant program

This is probably the most prominent factor and is the main reason for this communication. Hopefully, all physicians will come to realize that human cadaveric kidneys are a priceless resource that are the only practical instrument to restoring the health of young people with excellent rehabilitation potential.

II. Physicians do not know who might be a potential donor or how to contact the transplant team

The second purpose of this communication is to delineate our criteria for organ donors and how to

contact the transplant team. This will be outlined at the end of this communication.

III. The transplant program is at the County Hospital and does not merit the support of private practitioners

Although this reason is frequently raised, we are quick to dismiss it as being of no merit. We feel this is particularly true in view of currently presented data which indicate that the majority of transplant recipients were on dialysis in community hospitals.

IV. Families of cadaver donors will have inordinate, unnecessary expenses related to procurement of organs

Prior to July 1, 1973 the costs of procurement of cadaveric organs were reimbursable through a grant from the Wisconsin Regional Medical Program. Since July 1, 1973 these same expenses are to be covered by recipient's coverage under Medicare. Third party carriers also have recognized the financial advantage of transplanting dialysis patients and have indicated their willingness to cover donor costs. Costs to be covered include laboratory fees, operating room charges, neurological consultation, standby anesthesia, surgeons and surgeons' assistants fees.

V. Families of cadaver donors should not be subjected to the additional emotional trauma of having to give permission to donate organs

Permission to obtain organs should not be sought until the family fully understands that the proposed donor has sustained irreversible brain damage permitting a diagnosis of cerebral death. The family must also understand that continued artificial support (respirator, intravenous fluids, vasopressors) has no true potential for benefitting the patient and is merely prolonging the inevitable. When families truly understand the hopelessness of the situation, they usually accept requests for organ donation very calmly. Most become *enthusiastic* for organ donation as they see organ donation as the *only* good that can result from an otherwise hopeless and tragic situation. Since families are usually interested in the results from the procured organs, one of the senior surgeons writes a personal letter to the next of kin, who gave permission to remove the organs, informing them of the manner in which the organs were utilized.

VI. Concern of potential legal involvement

Laws have been enacted in 50 states regarding the procurement and transplantation of human organs. Section 7 (c) of the Wisconsin Uniform Anatomical Gift Act states, "A person who acts in good faith in accord with the terms of this section or with the anatomical gift laws of another state is not liable for damages in any civil action or subject to prosecution in any criminal proceedings for his act." While this does not absolutely protect physicians against "nuisance suits," the law is quite clear in its protection of individuals involved in the procurement of organs.

Wisconsin statutes do not have any definition of death and presumably current standards, as defined and practiced by the medical community, are the criteria to be utilized in pronouncing death. The State of Kansas passed a recent statute which recognized brain death in addition to the more standardly recognized cessation of cardiac action. On May 25, 1972 a jury in the Law and Equity Court of the City of Richmond, Virginia, ruled in favor of the defendants and upheld that the brain of the donor, in question, had suffered "total and irreversible damage" and that said donor was medically, and *legally*, dead. Therefore, although Wisconsin statutes do not define criteria for death, medical criteria for brain death seem well established and do not seem vulnerable to legal challenge.

Assuming that this report will inform, and hopefully stimulate, community physicians of the fact that the transplant program both serves, and relies upon, community hospitals and physicians, an outline of current criteria for cadaver donors is listed below:

Donor Criteria

1. Age—10 to 55 years
2. Type of patient (brain death or irreversible coma with intact circulation)
   - (a) Cerebral injury
   - (b) Primary CNS malignancy
   - (c) Subarachnoid hemorrhage
3. Criteria for brain death (irreversible coma)
   - (a) Specific diagnosis of cause of coma
   - (b) Total areflexia and absence of response to all external stimuli (except for spinal cord reflexes in some cases)
   - (c) Lack of spontaneous respiratory activity
   - (d) Isoelectric electroencephalogram is optional (some feel this should be the case for 24 hours; others feel that a single isoelectric encephalogram, with the other findings above, is adequate)
   - (e) Specifically excluded are individuals who are under central nervous system depressants or whose internal temperature is below 90 F (unless there is no improvement in central nervous system status restoration of normothermic conditions for 24 hours or longer)
   - (f) Patient is pronounced dead prior to being taken to operating room by the primary physician
4. Contraindications (at the time of initial evaluation)
   - (a) Sepsis (bacterial, viral, fungal)
   - (b) Patients arriving DOA (ischemic renal injury)
   - (c) Prolonged hypotension (ischemic renal injury)
   - (d) Malignancy (except primary CNS)
   - (e) Metabolic disease having potential of affecting kidneys (diabetes, lupus, and the like)
   - (f) Renal disease or hypertension
   - (g) Patients under central nervous system depressants or whose internal temperature is below 90 F

5. Screening procedures
   (a) A, B, O blood group
   (b) Urinalysis, including microscopic for cells, casts, bacteria and qualitative tests for proteinuria
   (c) Creatinine or blood urea nitrogen
6. Obtaining permission from relatives
   (a) It is essential that the family understands, and accepts, the hopelessness and irreversibility of the situation before the prospect of transplantation is mentioned. When the family does understand the hopelessness of the situation, it is desirable for the primary physician (or the neurologist or neurosurgeon consultant) to ask the family if they are agreeable to having the transplant team contacted. Their response will usually give an indication of whether they will give permission to use the kidneys.
   (b) If laboratory tests indicate donor is suitable, a member of the transplant team will talk to the family about donation and answer any questions the family might have. It is explained to the family that under usual circumstances, respiratory support of a patient with lethal head injury is not indicated and that cardiac arrest and death occur shortly after respiratory arrest. It is explained that temporary respiratory support would be instituted, not for the donor's benefit, but in order to purchase the necessary time to get the recipient to the hospital and operating room. It is essential that the family understands, and agrees to, this temporary respiratory support, and to the discontinuation of this support after the removal of the kidneys.
   (c) Permission to remove the organs is obtained from the responsible family member prior to removal of the kidneys using a standard operative consent form labeled, "Removal of Kidneys for Purposes of Transplantation and Termination of Artificial Respiratory Support."
7. Surgical procedures
   (a) Routine sterile exploratory laparotomy and nephrectomy
   (b) Kidney is perfused with cold Ringer's lactate—heparin, albumin solution and transported in a sterile container which the transplant team will provide
   (c) Kidney removal can be performed at whatever hospital prospective donor is being cared for
   (d) A member of the transplant team will surgically assist community surgeons with kidney removal whenever they desire such assistance
8. Telephone numbers
   H. Myron Kauffman, Jr, MD
   Office: 257-5523 Home: 782-6488
   Paul S. Fox, MD
   Office: 257-5523 Home: 258-5935
   Transplant Unit, Milwaukee County General Hospital: 257-5411

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Tributes

Excerpts from a collection of letters

"My deepest thanks for all that you did for me while I was at the old County Hospital as the first resident in orthopedic surgery that the County Hospital had, and which, largely due to your energy and foresight, was established. I likewise remember all of the kind personal things that you did, such as taking me one stormy night in your car to help me dig my wife out of a snow drift where she had gotten buried in Wauwatosa. You did so many things to make life easier for all of us."

—J. Irving Tuell, MD, Seattle, Wash.

"I am sure you are justifiably proud of the outstanding record you have compiled during your years in the medical profession as an outstanding teacher and 'substitute father.' Many of your 'boys,' and I am proud and honored to be considered one of them, owe you a debt we can never repay. We have learned from you many professional skills, but in addition we have learned even something more valuable—love of God, love of family, love of one's fellow man, and how to be a humanitarian in this complicated world."

—Leo R. Weinshel, MD, Milwaukee

"I can remember you in roles as a private surgical practitioner, a surgical preceptor for a young general surgeon embarking on his career, a surgical teacher, and a medical administrator. You gave sincerity and interest to each of your functions. Under that gruff exterior and gravel voice was a warm hearted and concerned surgical practitioner and surgical teacher. You felt personally responsible for the patients under your care and the residents in your training program. Your interest in your residents continued long after they left your training program and established themselves in their own surgical practices. You administered your department with justice tempered with understanding and kindness. You gave your loyalty to the department of surgery. In return, your residents and associates gave their loyalty to you."

—Raymond Harkavy, MD, Milwaukee

Figure 1—View of the concave surface of the sacrum with the tumor in the mid-region.

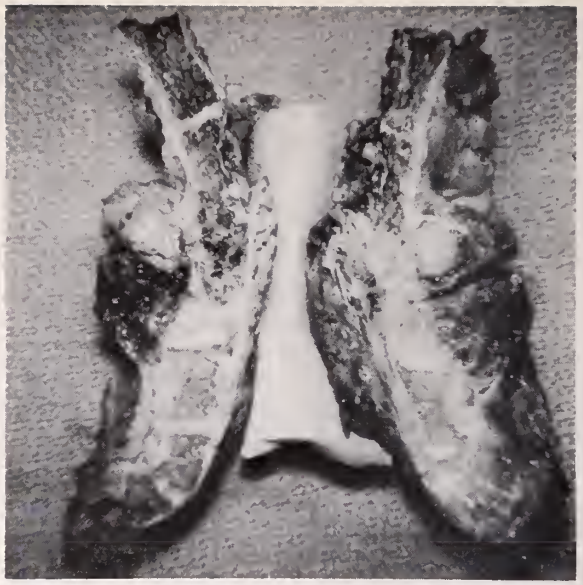

Figure 2—Sagittal section of the sacrum and the tumor.

CHORDOMA: Case Report

ERNEST J. ZMOLEK, MD
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CHORDOMA IS A RELATIVELY rare neoplasm of notochordal origin most frequently found at the caudal and cranial extremities of the spinal cord. However, it can occur in the lumbar, dorsal and cervical regions of the vertebral column. It was first described by Luschka and Virchow's Laboratory in 1857. The prevalence is in males three to one. Chordoma is a locally invasive tumor that tends to destroy and replace the bone at the site of development. It most commonly grows relatively slowly but infrequently may grow progressively and rapidly. Reports of metastases to distal regions of the body vary from 10% to 43%. Chordoma appears as a fleshy encapsulated tumor divided by fibrous trabeculae. Microscopically it contains nonvacuolated polygonal and vacuolated mucin-containing cells. Interspersed between this lobar arrangement of cells is a homogenous mucin matrix.

Case Report

A 65-year-old Caucasian man complained of having fallen on the ice in December 1972. Following this fall he complained of a vaguely described pain in the rectal and pelvic area. He had been seen at another institution, x-ray films of the lumbosacral spine were taken, and he was told that these were negative for injury. In May 1973 he was unable to inform me the exact site of his pain. The distress occassionally felt as though he was sitting on a ball and then the pain would subside. He was able to sit for only a short period before the pain would return.

An investigation of his history revealed that he also had had chronic ulcerative colitis with his last exacerbation two months before his fall. He also was known to have diabetes mellitus and was taking medication for idiopathic epilepsy. Examination revealed a very slender, anxious individual with most of the physical examination being otherwise within normal limits except for the rectal examination. Just above the coccyx and on the anterior wall of the sacrum was a palpable non-movable slightly tender mass, roughly one and one-half inches in length and one inch in transverse diameter. Sigmoidoscopy was normal. X-ray studies of the lumbosacral spine were reported as normal. With a finger in the rectum, a Silverman needle was introduced through the perineum into the mass and a plug of tissue obtained for histologic study. The histologic diagnosis was chordoma.

The problem was explained to him and he then returned to the hospital for definitive surgery which was done on June 15, 1973. Through a midline incision over the sacrum and coccyx the sacrum was exposed. The posterior spines of the sacrum were exposed. The sacral canal was unroofed exposing the relationship of the tumor to the sacral nerves and foramina. The nerves S2 on the left and S3 on the right were separated from the bone, elevated and then the sacrum transected through the foramina of S2 on the left and S3 on the right. It was hoped that by salvaging these two nerves that the urinary and fecal continence would be preserved. The specimen including the distal sacrum, the coccyx, and the tumor were separated from the remaining soft tissues and removed.

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There was a firm area of tissue on the posterior wall of the rectum which was dissected free and preserved as a separate specimen. In fact the rectum was explored through an incision posteriorly, but the mucosa again was all intact. The rectum was carefully closed with sutures as was the remainder of the wound. After surgery the patient was noted to have poor anal tone but he was able to weakly, voluntarily contract the anal region. However, he was unable to void. Recognizing the fact that the patient had some symptoms of prostatism he was subjected to cystoscopy by the urologists and a transuretheral prostatectomy was accomplished on July 5, 1973. Four days later he was voiding. For another three weeks he experienced urinary incontinence especially during the night hours.

The pathologist described a tumor on the concave surface of the lower sacrum measuring 3.5 cm x 3 cm and when examined further was noted to infiltrate and destroy both cortical surfaces of the sacrum involved. It was thought that the tissue dissected from the posterior wall of the rectum was a hematoma most probably caused by the needle biopsy of the chordoma. In this tissue, however, along one margin was an infiltrate made up of neoplastic cells similar to those described in the sacral lesion.

Since the date of his discharge from the hospital, he has been followed at the office. The right buttock region feels normal to him. This is the side on which the nerve S3 was preserved. He still complains of discomfort as though he was sitting on a rope located in the region of the left buttock. This is the side on which the nerve S3 was included with the specimen in order to remove the grossly observed tumor. This also is the side that the nerve S2 was elevated and separated from the specimen and some traction was applied to it for a relatively short time. He seldom has any difficulty with urinary incontinence. He does, however, complain of constipation which has been rather stubborn. Occasionally he has mild fecal soiling. He is quite unhappy with the fact that the distress on the right buttock region has cleared and that it has persisted on the left side. He is unable to sit except for very short periods and can only take short rides in the automobile because of this distress.

Comment

It is commonly recognized that chordomas are rare and that most chordomas remain localized.

JOSEPH M. KING
Festschrift

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Chordomas commonly grow slowly, often recur locally, but infrequently will metastasize to distant sites. The generally accepted method of treatment of localized chordoma is surgical. Radiation does not play an important role in the curative management of this disease because of the low radiosensitivity to these tumors. Preoperative irradiation may be beneficial. However, favorable results have been reported with long-term survival combining surgery and later aggressive radiation therapy for local recurrence. Very vigorous dosages of irradiation, however, have been used. The use of super voltage radiation recently has been used for the skin and bone sparing effects. To palliate symptoms of metastatic chordoma such as pain, super voltage radiation and even chemotherapy have been prescribed. A review of the literature reveals that surgical therapy has been extended to hemi-corporectomy in appropriate and selected cases.

The patient in this case report is only 50% satisfied with the results of his therapy. The symptoms in the right buttock and anal region have been relieved but they are still present on the left. He described them as being somewhat different than before the surgery, but the distress is very aggravating to him. Only time will tell as to whether these symptoms will improve and if and when he develops a local recurrence and/or metastasis. □

TRIBUTES to Doctor King **Excerpts from a collection of letters**

"Dr. King, you have played an important part in my life, for if you remember, it was in the midst of World War II that you accepted me into the EENT resident service in the Surgical Department at County. Those were trying days for anyone with the name and features like mine, but you saw to it that I was accepted into the medical community of Milwaukee. I shall never forget those days, and I am truly thankful for all that you have done for me."

—M. Tofukuji, MD, Wailuka, Maui, Hawaii

"Nobody ever made more of a lasting and profound impression on me than Dr. King. He to me is one of the most unselfish, ethical, intelligent physicians I have ever met in my life. On top of this, Uncle Joe was a very capable surgeon, and had a tremendous sense of humor. If all the hundreds of young men to whom Dr. King dedicated his life are half as good as he is as a human being, we should have no trouble with the future of medicine."

—Eugene F. Senseny, MD, Fort Wayne, Ind.

"But if The Old Man orders it" . . .

Doctor King, I would like to remind you of two cases you were involved in that I remember.

A policeman was brought in who had been peppered on his abdominal wall with a shotgun blast from about 40 feet away. We washed his wounds and removed some loose pellets. His abdominal x-ray showed numerous imbedded round shots.

The young assistant chief of surgery and all of us residents and a visiting staff man or two all agreed that there was no chance of intra-abdominal injury in a case such as this. You, as police surgeon, were called as a matter of course, and you came and looked at the man.

We showed him to you, you looked at his films, you felt his sore abdomen, you looked in his eyes. You tended to agree with us. The range was too great. He really wasn't very tender. The x-rays were quite unremarkable except for the large number of foreign bodies, which were undoubtedly all in his abdominal wall.

And yet . . .

The operating crew had just gone home after a case. We hated to call them back.

"Take him to the operating room," you said.

The assistant chief looked at us, we looked at him. Eyebrows and shoulders went up imperceptibly.

It was going to be an unnecessary exercise. But if the Old Man orders it . . .

You opened him up, widely, with about two firm slashes. The assistants dived for the bleeders; that is what assistants are for.

You found 11 perforations in the small bowel. Peritonitis was already starting, and there was a lot of blood around. You rooted out each perforation and closed it like it was your personal enemy. In the course of the procedure a fly started buzzing around the operating room and your oaths were horrendous to hear. Somebody swatted the fly and you closed the last perforation, handing the BB shot to the scrub nurse.

I thought, "Eleven perforations. How does he know he got them all?"

A week later the policeman walked out of the hospital and three weeks later he was back on the beat.

The other case was an old Russian gentleman, a former Tsarist colonel. After World War II he migrated here with his children and grandchildren. He did not speak a word of English. He was sick, with jaundice—painless but itching jaundice. He had lost his appetite, lost much weight, and here he was in a ward at Milwaukee County Hospital.

We worked him up as best we could with the language problem—students, interns, residents.

We showed him to you on Saturday morning rounds. He sat up in bed, steel-gray hair and moustache, his military background still evident in his upright bearing—a handsome, intelligent-looking man, in spite of his 75 years, his illness, and his incomprehension of the language around him. His son stood at the bedside to interpret.

He looked at you and you looked at him, and something clicked between you. Two aristocrats recognized each other—two members of the ruling class, across wide culture, era, language and geographic distances.

You turned to us and said, "Think what it must be like to be sick, and old, and broke—in a foreign country where you can't understand, and no one can understand you."

You turned to the colonel and said, "We're going to operate on you; we'll do the best we can to help you." His son translated this and the old man broke into a smile and nodded his head. You both shook hands.

You and I opened him up a couple of days later, Doctor King. He had a hard mass in the head of his pancreas.

"That's a cancer," you said.

"Should we biopsy it?," I asked.

"No, we will not biopsy it," you replied.

"Shall we do a Whipple procedure?"

"No, we will not do a Whipple procedure," you said emphatically. "You will connect his gallbladder to his jejunum, and you will do this in such a way that bile runs into the jejunum, but intestinal juice does not run into the gallbladder."

So I did a cholecysto-jejunostomy, with you helping . . . a bit restlessly at times.

One week later, his jaundice fading, his appetite improving, he left the hospital.

Three years later, his son, in the hospital for another reason, told a senior resident who remembered him, "Dad still feels fine."

—WILLIAM B. GALLAGHER, MD, La Crosse

The Effect of Surgery on Cellular Immunity

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JOSEPH M. KING
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THE STRESSES OF SURGERY generate an integrated series of reactions initiated by the release of such substances as glucocorticoids, ADH, catecholamines, and aldosterone. Since the ultimate goal is preservation of homeostasis, one would expect that the immunologic system would also participate in such a generalized protective reaction. Evidence for this is meager.

Normal circulating lymphocytes of the peripheral blood undergo morphologic change and mitotic division when exposed in vitro to various plant extracts such as phytohemagglutinin (PHA)[1] and pokeweed mitogen (PWM).[2] Experience to date suggests that the majority of PHA-responsive lymphocytes are the "T-lymphocytes" of thymic origin, whereas both "B-lymphocytes" (bone-marrow derived) and T-lymphocytes can be stimulated by PWM.[3,4] This lymphocyte-transforming property of PHA and PWM becomes altered in a variety of disease states generally associated with an impaired capability to respond immunologically (e.g., Hodgkin's disease,[5,6] lymphatic leukemias,[7] sarcoid[8]). Preliminary communications suggest that the transforming capabilities of lymphocytes in response to PHA are also altered following surgery.[9,10] Whether this response is related to the magnitude of the surgical procedure, the use of inhalation anesthetics, the release of inhibiting substances from traumatized tissue, or other unrecognized variables is not known.

In this investigation we have studied the effect of two surgical procedures of greatly differing magnitudes (inguinal herniorrhaphy and gastrectomy) on the lymphocyte response to PHA and PWM. Clinical variables were examined and statistical analysis used for correlation.

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Materials and Methods

Patients were separated into two categories. Twelve patients in Group I underwent laparotomy and gastric resection. Nine patients in Group II underwent a total of 10 inguinal herniorrhaphies. There was no preselection except for the elimination of patients with cancer or any systemic disease generally associated with altered immunologic responsiveness.

After determining the patient's willingness to participate in the study, blood specimens for PHA and PWM assay were drawn preoperatively and on postoperative days 1, 4, 7, 14, and 21. The patients otherwise received that care dictated by their particular clinical course. Thirty ml of venous blood was obtained in a heparinized plastic disposable syringe and with the syringe in an upright position (needle end up), the erythrocytes were allowed to settle for 1-2 hours at room temperature. The leukocyte-rich plasma and buffy coat were expressed into a sterile plastic centrifuge tube. The cell suspension was centrifuged at 1,200 rpm for 10 minutes, plasma removed, and the cells suspended and centrifuged three times with culture medium. Lymphocytes contained in the suspension were counted and the volume adjusted by adding culture medium to contain 10^6 lymphocytes per milliliter.

Two ml of culture medium suspended cells were placed in each of nine 16 x 100 mm disposable glass culture tubes. Culture medium consisted of: Eagles Minimal Essential Medium (Gibco) containing 1% L-glutamine, 100 units/ml and 100 mcg/ml, respectively, of penicillin and streptomycin and 10% heat activated human group AB serum.

Fifty lambda of phytohemagglutinin (PHA-M) (Difco), diluted according to the manufacturer's directions, were added to each of three tubes containing cell suspension. Fifty lambda of similarly suspended pokeweed extract (PWM) (Gibco) were added to another three tubes containing cell suspension. The remaining three tubes were retained as unstimulated controls. Similarly treated cells obtained from healthy normal individuals served as control cultures.

Lymphocyte cultures were incubated at 37 C, 100% humidity and 5% CO_2 for 72 hours.

After incubation, the individual culture tubes were centrifuged for 10 minutes, the supernatant was removed and the cells suspended in 5 ml of a 50% dilution of isotonic saline with distilled water. After 10 minutes at room temperature, the suspensions were centrifuged at 1200 rpm for 10 minutes, supernatant carefully removed and the cells suspended in the small amount of remaining supernatant. Dropwise 1 ml of fixative (glacial acetic acid: absolute ethanol at ratio 1:3) was added to cells, then 4 ml of fixative was added. After 10 minutes at room temperature, the suspensions were centrifuged for 10 minutes at 1200 rpm, all but 3-5 drops of supernatant removed and cells suspended in the remaining supernatant. For each culture tube, one drop of suspension was placed on each of two cold slides, gently blown to spread and then heat fixed. Slides were stained with dilute Giemsa in buffer consisting of 8.1% 0.1M citric acid, 11.5% 2 M Na_2HPO_4 (1 drop Giemsa: 1 ml buffer). On each slide 100 cells were counted with a tally of the lymphoblasts and of the lymphocytes. These data yield the proportion of cells in blast transformation.

While some investigators have suggested that variability in PHA assays in normal individuals is quite small,[10] others have suggested a wider variation, not only from individual to individual but also in the same person from day to day.[11,12] In order to reflect more accurately the distribution of the general population, we therefore combined the preoperative observations of the patients under study with the values of the nonoperated volunteers to obtain the normal control mean. After subtraction of unstimulated from stimulated values for both PHA and PWM, calculations were performed using the Student's t-test for statistical significance.

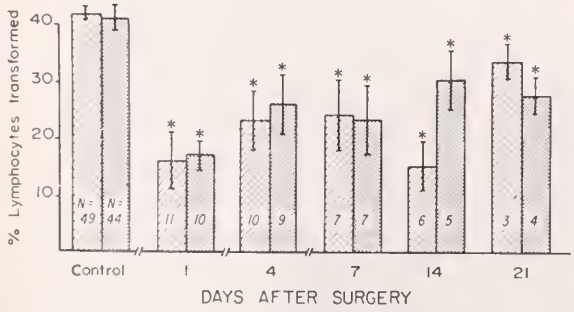

Figure 1—PHA-induced lymphocyte transformation —mean values in patients undergoing gastric resection (striped bars) or inguinal herniorrhaphy (shaded bars). N represents the number of patients studied. Vertical lines equal SEM. There was a significant depression in the PHA assays (*denotes p <.05) throughout the period of observation in both groups.

Results

Phytohemagglutinin Assay

Figure 1 summarizes the effect of gastrectomy and inguinal herniorrhaphy on the lymphocyte response to PHA. In both those patients undergoing gastrectomy and those undergoing herniorrhaphy, there was significant depression ($p<.05$) of the lymphocyte response on each of the 5 days tested during the 21-day period of observation. Neither the degree of depression nor its duration were statistically different between those with the more major procedure (gastrectomy) and those with the more minor procedure (herniorrhaphy).

Most patients (9 of 12 with gastrectomy and 8 of 10 with herniorrhaphy) followed a general pattern of most marked depression of lymphocytic response on the first postoperative day with a gradual return toward mean control levels over the ensuing 21 days. There was, however, some degree of variation from this pattern. For example, following gastrectomy in one patient and herniorraphy in two patients, the maximum depression of the lymphocyte response was not observed until the 4th postoperative day. The maximum depression was delayed until the 7th postoperative day in an additional gastrectomy patient. Still another individual exhibited virtually no alteration in lymphocyte responsiveness except for an insignificant depression on the 14th postoperative day.

In 4 of 21 patients there was a depression of lymphocyte response to PHA on the one preoperative determination. One of these patients had insulin-dependent diabetes mellitus and extensive atherosclerosis. A second patient had been taking phenylbutazone (Butazolidin) for "arthritic" back pain. Whether these factors are causally related or whether these patients represent extremes in normal variation is not known.

Three herniorrhaphies were performed under spinal anesthesia. The depression of the lymphocyte response in each instance was similar to those receiving general inhalation anesthetics.

Pokeweed Mitogen Assay

Figure 2 summarizes the effects of both gastrectomy and inguinal herniorrhaphy on the lymphocyte response to PWM. There was a significant depression ($p<.05$) of the lymphocyte response following gastric resection on the 1st, 4th, 7th, and 14th postoperative days with return to control levels by day 21. In contrast, the mean lymphocyte response to PWM in the herniorrhaphy group was depressed only on the 1st postoperative day. In 2 of these 6 patients, however, the response did remain depressed through the 14th and 21st days, respectively. Again, individual variability was illustrated when, following gastric resection, the maximum depression of lymphocyte response did not occur until the 4th postoperative day in two patients. A lady with inactive

tuberculosis, emphysema, and chronic salicylate ingestion showed no depression of lymphocyte responsiveness following gastrectomy. In two patients a preoperative determination was depressed without apparent reason.

Discussion

As a result of the growth of immunology during recent years, methods have been developed of clinically estimating cellular immune reactivity (e.g., skin testing with antigens, lymph node biopsy). In the search for better ways of evaluating cellular immune mechanisms, it was observed that the plant lectin, phytohemagglutinin, when incubated with normal lymphocytes of the peripheral blood, induced morphologic change or mitotic division in a high proportion of cells.[1]

In a variety of disease states affecting immunity in general (e.g., sarcoid, hepatitis, measles, chronic mucocutaneous candidiasis), or in diseases involving lymphoid tissues (e.g., Hodgkin's disease, chronic lymphocytic leukemia) or in patients receiving immunosuppressive therapy, the ability of PHA to transform lymphocytes was often depressed.[5,6,7,8] The observed depression of lymphocytic responsiveness was generally of such magnitude that an altered ability to respond immunologically could be readily recognized.

Whether there is a direct relationship between the immune competence of lymphocytes and their inability to transform when exposed to PHA, or whether this failure to transform in PHA reflects only a more generalized impairment of reactivity to any stimulus, including antigens, is unknown.

A different mitogen, the pokeweed mitogen (PWM), from the plant Phytolacca americana, also

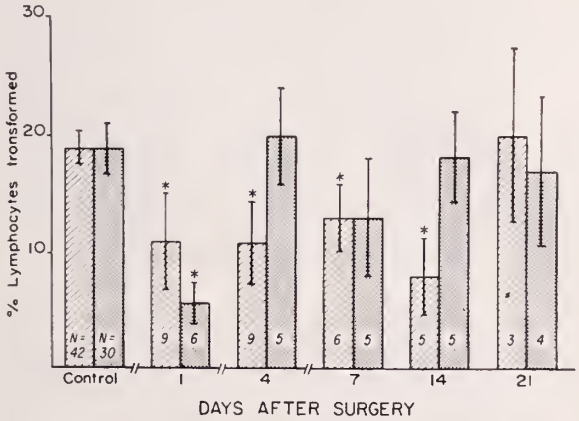

Figure 2—PWM-induced lymphocyte transformation—mean values in patients undergoing gastric resection (striped bars) or inguinal herniorrhaphy (shaded bars). N represents the number of patients studied. Vertical lines equal SEM. There was a significant depression in the PWM assays (*denotes $p < .05$) through day 14 in the gastrectomy group but only on day 1 in the herniorrhaphy patients.

causes blast transformation of lymphocytes.[2] It has been less thoroughly investigated but there is evidence of morphological and biochemical difference between the cells responding to PWM and PHA. Experience to date suggests that the majority of PHA-responsive lymphocytes are the "T" cells of thymic origin (T-lymphocyte), whereas both T-lymphocytes and thymic independent, bone-marrow derived B-lymphocytes can be stimulated by pokeweed mitogen.[3,4] The thymus-derived cell and bone-marrow cell interact synergistically in the development of an antibody response. One can also consider, however, the function of these two cell types to be at least partially restricted to humoral (B-lymphocyte) and cell-mediated (T-lymphocyte) immune reactions.[13]

Few studies have examined the role of surgical trauma in altering immune mechanisms. It is difficult not to incriminate an altered immunologic surveillance system in those patients who develop explosive metastases or overwhelming infections with opportunistic organisms following a surgical procedure. Riddle and Berenbaum measured the lymphocyte response in a small number of unselected patients undergoing surgery.[9] There was a consistent depression in the percentage of lymphocytes undergoing transformation when exposed to PHA. Park et al measured the comparative immune reactivity of peripheral blood lymphocytes by stimulating them with PHA and determining their ability to incorporate ^{14}C thymidine.[10] This was taken as a measure of DNA synthesis needed for antigen recognition and for initiation of the immune response. In all surgical patients studied there was a decrease in ^{14}C thymidine incorporation into lymphocytes, most marked and prolonged in those patients with associated cancer or heart disease.

We have confirmed a significant and prolonged depression of peripheral lymphocyte transformation following both inguinal herniorrhaphy and gastric resection when the cells were cultured with PHA. When exposed to PWM, a similar response was seen in those patients undergoing gastric resection, but only a transient depression on the first postoperative day in those patients subjected to herniorrhaphy.

Several theories to explain the observed alterations in immunologic response have been offered. One explanation attributes the depression to the endogenous steroid release caused by any "stressful" situation. In the current study the PHA-incubated lymphocyte response was depressed throughout the observation period of 21 days in both herniorrhaphy and gastrectomy patients. Likewise, the PWM-incubated lymphocytic response was depressed between 14 and 21 days in the patients with gastric resection. Since plasma glucocorticoid levels following uncomplicated gastrectomy return to normal by the third postoperative day,[14] other mechanisms must be invoked to explain the prolonged response.

It has been suggested that inhalation anesthetics of themselves may depress lymphocytic responsiveness. In our series three herniorrhaphies performed under spinal anesthesia all caused a significant and sustained depression of lymphocyte response to PHA. This confirms Powell and Radford's in vitro experiments that incriminate mechanisms other than the inhalation anesthetic agents in the alteration of the immune response.[15]

The alteration of the B-lymphocytic response to PWM was quantitatively less significant in the herniorrhaphy group, where there was a transient depression only on the first postoperative day, than in those with gastrectomy where the altered responsiveness persisted longer than 14 days. The depression of the B-lymphocytic response may thus in some way be related to the degree of tissue trauma invoked by the operative procedure and suggests possible release of an inhibitor substance.

Whittaker et al found a factor present in the serum of patients with cancer of the breast which, when combined with lymphocytes of healthy persons, reduced the lymphocyte-transforming properties.[16] In Park's series of postoperative patients, a similar depression in PHA transformation properties was found when either patient plasma was combined with normal lymphocytes or when normal plasma was combined with patient lymphocytes.[10] He postulated that in addition to the lymphocytes themselves being sensitized, the plasma also contains inhibiting substances. If such substances are involved, the quantitatively similar responses in the T-lymphocytic series after both herniorrhaphy and gastrectomy would suggest an "all-or-none" effect on this cell line.

While it is clear that these studies indicate that surgical trauma alters cellular immunity as measured by the lymphocytic response to PHA and PWM, direct clinical application is less obvious. In spite of marked and prolonged depression of immune responsiveness following surgery, few patients develop postoperative complications which can be attributed to an ineffective immune mechanism. What can be emphasized, however, is that every surgeon faithfully adheres to established surgical principles for limitation of contamination, prevention of infection, and isolation of tumors so that following surgery, an already compromised immunologic system will not be overburdened to the point of failure.

Summary

To investigate alterations in cellular immune reactivity caused by surgery, the lymphocyte response to phytohemagglutinin (PHA) and pokeweed mitogen (PWM) was studied in two groups of patients undergoing surgical procedures of greatly differing magnitudes. Following both partial gastrectomy and inguinal herniorrhaphy, there was significant depression of the lymphocyte response to PHA throughout the 21-day period of observation. In the herniorrhaphy patients, an initial depression in lymphocyte response to PWM had returned to control levels by the 4th postoperative day but this did not occur until the 21st postoperative day in the gastrectomy group. The mechanisms by which surgery alters immune responsiveness are as yet unknown but release of inhibitor substances from traumatized tissues is suggested.

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"I have had many happy memories of my association with you through the years of 1931, 1932 and 1933. You are an excellent teacher and have a memory like an elephant for names and medicine. About thirty years after my residency, I visited in your surgery gallery at County. You looked up from surgery and, seeing me, said 'Hello Pomainville, how are you.' Remarkable after all those years. You are an avid historian."
—LELAND POMAINVILLE, MD, Wisc. Rapids

"Perhaps your greatest attribute was to instill in both the medical students, interns and residents a common sense approach to the specialty of surgery. Many times I have blessed you after attempting to approach a problem as I felt you would have attacked it. Your second greatest attribute was your memory, not only of medicine but of your staff in years gone by. I am sure today you can recall your former residents despite the many years and numerous residents who passed through your service. Each of them, as I, thank the Good Lord for Doctor Joseph M. King."
—GEORGE H. WALLER, MD, Decatur, Ill.

"From time-to-time when I have been caught in desperate surgical situations, the lessons learned of former years come through repeatedly loud and clear and for this I am indeed grateful. Not only a variety of experience did we receive at the County Hospital, but we learned other lessons as well from you. One especially was your concern for the patient."
—JOSEPH J. SCHECHTER, MD, Upland, Calif.

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TRIBUTES

Excerpts from a collection of letters

"I want to thank you and congratulate you for many years of the tremendous contributions you have made to medicine and the lives of individuals such as myself."
—Russell R. Redlin, MD, Wauwatosa

"Along with your many friends and colleagues, I have also been one of your admiring fans. This dates from the time I spent some summers at the County Hospital, through the past twenty-six years to the present, and will continue into the future. Somehow, there was never an opportunity to tell you this—or the words would not come. Your example in many situations has been a model in which I have tried—not always successfully—to follow. Your friendship has been a warm and cherished part of living in Wisconsin. Thank you for the countless good things you have done for so many people."
—Albert G. Martin, MD, Milwaukee

"It was some 37 years ago, as a student at Marquette University Medical School, that I had my first real contact with you. During those times, it was the custom to respect all instructors and professors with an awesome attitude. As is well known, those conditions have dramatically changed in the last decade due to what psychiatrists call the 'generation gap.' However, my respect for you as 'Heir Professor' still proudly exists."
—W. P. Wendt, MD, Milwaukee

"Your insistence on proper surgical discipline, diagnosis, and pre and postoperative care fundamentals have carried with me ever since and are a part of my daily practice life. I hope I have followed your lessons well. I believe more important, Doctor King, is the impact you exerted on all of us as to personal honesty, sincerity and compassion not only with patients but to all with whom you had any contact."
—Frank A. Hill, MD, Grand Forks, N.D.

"I have been fortunate to have had my internship and residency under your supervision. Any success or accomplishments that I have had I owe directly to you as a surgeon, teacher and friend. P.S. I quit smoking some years ago."
—George P. Schwei, MD, Menasha

"It gives me great pleasure to join many other surgeons in Wisconsin and other communities in offering congratulations on this occasion for your many years of outstanding service to Milwaukee County General Hospital and Marquette University Medical School."
—Paul J. Collopy, MD, Milwaukee

"I wish to join the people of Wisconsin Medicine in honoring you as an illustrious physician, and a surgeon, who has given enormous services to the community."
—Emmanuel L. Onlayao, MD, Grafton, Ohio

A Comparison of Arterial and Venous Lactate Levels in Low Flow States

ROBERT ORRINGER and LARRY C. CAREY, MD, Pittsburgh, Pennsylvania

JOSEPH M. KING
Festschrift
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SHOCK IS A CLINICAL diagnosis. The absence of a laboratory test to quantitate shock continues to be an impediment to ideal treatment. It has been reported that measurements of serum lactate concentration can be used as an adequate index of shock.[1] A patient in hemorrhagic shock will display a noticeable increase in serum lactate concentration. Lactate is a product of anaerobic cellular metabolism which results from oxygen deficiency due to inadequate cellular perfusion. As the shock condition is ameliorated, the serum lactate level correspondingly decreases owing to increased lactate oxidation. This oxidation is made possible due to increased cellular perfusion.

Customarily, serum lactate samples have been withdrawn from arterial blood. The disadvantages in using arterial samples are the difficulty in obtaining samples from these deep high-pressure vessels and the hazard to the patient of vessel damage, e.g. internal hemorrhage. Peripheral vein cannulations, however, present no major difficulty in obtaining adequate samples. Currently most patients in shock have a central venous catheter. The purpose of this study is to determine the reliability of using peripheral (and central) venous serum lactate measurements as indicators of shock.

This study was carried out in two parts. First, serum lactate concentrations were determined from arterial, central venous and peripheral venous blood samples of pigs that had been bled into hypovolemic shock. In the second segment of the study, patients undergoing open heart surgery were sampled for serum lactate concentration from blood specimens drawn from an artery, peripheral vein and central vein. In each case it was determined whether there was correspondence among the lactate concentration measurements from arterial, central venous, and peripheral venous samples.

Methods and Materials

Part I

In this study, five pigs (mean arterial pressure between 105-120 mm/Hg) weighing between 16.6 and 25 kg were used. The hemorrhagic procedure was conducted over a two-day period. On day one, a pig was anesthetized with 28.8 mg/kg sodium pentobarbital and subsequent injection as needed. Two bilateral groin incisions were made. On the right side both the femoral artery and vein were cannulated with appropriate lengths of heparinized polyethylene tubing. Each catheter was inserted approximately 8 cm into the vessel and sutured into place. On the left side, a heparinized polyethylene catheter was introduced into the femoral vein and threaded up into the inferior vena cava and secured at a point just outside the right atrium. (Location of this catheter was ascertained by monitoring pulse pressure through the catheter using a Statham transducer and Grass polygraph. The catheter was inserted into the right ventricle and then withdrawn to the point where the atrial pulse became undiscernible.) After incisions were closed the animal was returned to the animal quarters for recovery.

On day two, the unanesthetized animal was placed in a Pavlov stand and a baseline serum lactate sample was taken from all three catheters. Hemorrhagic shock was then induced by bleeding the animal arterially by 30-40% of its blood. The amount bled was determined from knowing the total blood volume as computed from the blood volume/weight relationship.[2] After hemorrhage was completed, arterial pressure had dropped to below 55 mm/Hg. The animal was kept in shock for 90 minutes and samples were taken from all catheters at 30-minute intervals. The animal was then autofused and two additional samples were taken. Blood samples were analyzed for serum lactate concentration using Beochemica Test Combination and ultraviolet spectroscopy procedures.[3]

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Part II

In the second part of this study, serum lactate samples were obtained from five cardiac patients. All of the patients required surgery which necessitated the use of the cardiopulmonary pump. In these procedures, use of femoral and central venous catheters is standard procedure. In addition, a peripheral venous catheter was placed 8 cm in the femoral vein.

Patient No. 1 was an adult female. This patient was on the cardiopulmonary pump for 11 minutes.

Patient No. 2 was a young adult female. This patient was on the cardiopulmonary pump for 14 minutes.

Patient No. 3 was an adult male. This patient was on the cardiopulmonary pump for 40 minutes. This length of time on bypass allowed for samples to be withdrawn from the patient during this period.

Patient No. 4 was a 9 year-old male child. This patient was on the cardiopulmonary pump for 13 minutes.

Patient No. 5 was an adult female. This patient was on the cardiopulmonary pump for 20 minutes.

Blood samples for lactate concentrations were taken from arterial, central venous, and peripheral venous catheters. Samples were taken before the patient went on the cardiopulmonary pump (baseline) and at post-pump intervals of +30, +60, +120, +180, and +240 minutes. As was already noted, an additional sample was obtained from Patient No. 3 while he was on the pump. All samples were analyzed for serum lactate concentration and results compared.[3]

Results

Part I

In the five pigs studied, there was shown to be essentially no difference in the rate of lactate increase from the three sampling sites. In addition, the absolute values of the lactate measurements were very similar. Absolute peripheral venous lactate values may be slightly higher than the others; however, this result cannot be shown to be statistically significant.

Initially after hemorrhage, arterial blood pressure dropped from a basal mean of 112 mm/Hg to a mean of 44 mm/Hg, a net loss of 61%. In the same period of time, lactate concentrations at all three sampling sites increased from a basal value of 17.5 mg/ml to 57.4 mg/ml, a net increase of 3.3 times the basal value. Over the next 90 minutes that the animal was in shock, the arterial pressure slowly increased to a mean of 84 mm/Hg. The lactate concentrations continued to increase slowly to 4.1 times the basal value during the first 60 minutes in shock. During the last 30 minutes of the shock period, the lactate concentrations began to fall.

When the animal was reinfused (90 minutes after hemorrhage), the arterial pressure returned to its basal level of 109 mm/Hg and the serum lactate concentration continued to fall (1.9 times basal at the last measurement.) At no time during the experiment was the change in lactate concentration from one sampling site significantly different from the value obtained from the other sites (Fig 1).

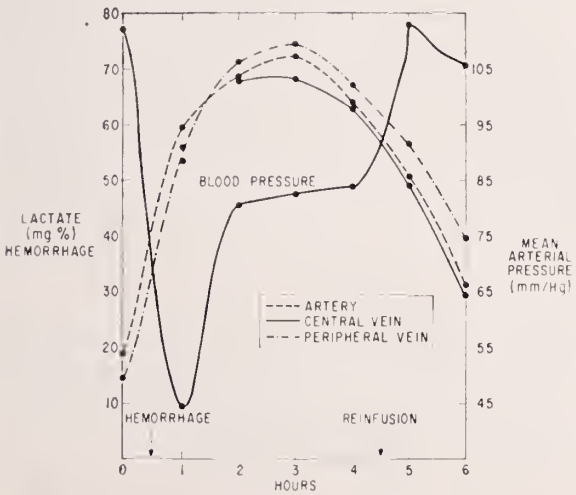

Figure 1

Part II

In all of the samples from the patients, the serum lactate concentrations, whether from an arterial, central venous, or peripheral venous source, were in agreement (Table 1). After the patient had been on the cardiopulmonary pump, it was found that lactate

TABLE 1

Sample			*Patient Number* 1	2	3	4	5
Pre-Pump		PV	13	12	13	29	25
		CV	14	20	13	27	21
		A	13	17	12	22	22
Post-Pump	*30 min*	PV	22	22	23	36	29
		CV	27	24	24	32	31
		A	23	24	28	28	33
	60 min	PV	22	24	33	31	31
		CV	24	24	29	28	33
		A	23	27	27	27	33
	120 min	PV	34	22	25	30	28
		CV	40	22	24	27	27
		A	30	24	35	22	21
	180 min	PV	39	19	38	22	21
		CV	34	21	29	21	24
		A	40	14	29	19	26
	240 min	PV	35	11	29	24	25
		CV	34	10	29	23	20
		A	33	10	27	22	19

PV = Peripheral Vein
CV = Central Vein
A = Artery

concentrations increased. The rate of increase varied among the subjects. It is important to note, however, that at no point was there any sizeable variation between the values obtained from the three sampling sites of a subject at any given time. Regardless of the time of the sampling with respect to time on bypass, lactate values corresponded to each other from all three sampling sites.

Discussion

Serum lactate concentration in a peripheral (or central) vein shows little difference from arterial values in monitoring the severity of shock. Huckabee's[4] investigation suggested that lactate concentration was not a good index of anaerobic metabolism. He described lactate excess and found it to be more consistent as an index of shock. His formula for excess lactate is:

$$\text{Excess Lactate} = (Ln - Lo) - (Pn - Po)\ Lo/Po$$

where Lo and Po are control serum lactate and pyruvate levels, Ln and Pn are serum lactate and pyruvate levels at sometime (n) when certain conditions are imposed on the organism, e. g., hemorrhage, exercise.

More recently, many investigators such as Weil and Afifi[1] have determined that serum lactate alone was more closely correlated with cumulative oxygen debt than excess lactate values. Furthermore it was shown that serum lactate concentration is a reliable predictor of survival or death in 88% of shock patients; 81% accuracy was achieved using excess lactate calculation. Lactate/pyruvate ratio yielded only 79% accuracy in prediction. Carey, Lowery, and Cloutier[5] found arterial lactate levels to be a good indicator of severity of shock and no advantage was gained from deriving excess lactate or lactate/pyruvate ratios.

On the basis of the data presented in this investigation, the accuracy of serum lactate as an index of shock severity holds not only for arterial samples but also for peripheral and central venous samples. It is seen that there is an insignificant difference among measurements of lactate concentration from the arterial, central venous, and peripheral venous sites.

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TRIBUTES

Excerpts from a collection of letters

"Ability as an educator is not given to everyone, and the proof comes slowly, as the student goes out and demonstrates the fact that he indeed did come away with real knowledge and ability to do what he was taught by such an able teacher as you were. Dr. Joe, I can say this, seldom do I step up to examine a patient with abdominal pain that I don't think of you, and first thought, what are the bowel sounds like, are there rushes and tinkles, or are there no sounds. Yes, there are many things that I learned from you, and over the years I have greatly appreciated it."

—C. E. Zenner, MD, Cadott

"I appreciate the 'many pearls' gleaned from your long experience in general surgery. I am certain that you will always 'stand tall' among the Surgeons and Teachers in Wisconsin Medicine."

—John J. Satory, MD, La Crosse

"Above all, I will remember you for your unassailable integrity. Yours was the larger honesty which comes from the total harmony of integrity in all one's relations to mankind. You were unswerving in seeking the truth in doing what you believed to be right, in focusing the wide-ranging interests of a surgical administrator and focusing them into the central category of dedication. Your care of the sick, your approach with your colleagues, your congenial methods of teaching intermingled with your religious faith which was simple, basic and unpretentious. You were always ready to give counsel and the last to portray undue criticism. You were in the true sense a humanitarian with which we as interns, and later residents, enjoyed the camaraderie of a good friend overflowing with the joy of a genuine living experience. It was an honor and a privilege to be a student and admirer of yours. Your skill as a surgeon, your compassion to mankind, and your astute knowledge and humility as a teacher will not only endear you forever to all of Wisconsin medicine, but to all who are privileged to call you friend."

—Edward A. Banner, MD, Rochester, Minn.

Nasal Cavity and Paranasal Sinus Malignancies: Review of 41 Cases

LEONARD P. RYBAK, MD and
ROGER H. LEHMAN, MD, Milwaukee, Wisconsin

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DESPITE A MASSIVE expenditure of funds for research and education, malignant tumors were the second leading cause of death in the United States in 1968.[1] Although cancer of the nasal cavity and paranasal sinuses constitutes only 3% of all head and neck tumors,[2] the effect on the individual can be devastating. Either the tumor itself or its treatment can destroy parts of the face, posing a real threat to the body image.

In most cases a preventable cause cannot be identified, but chronic irritation may play a role. A few cases of oral-antral fistulas have been found to have carcinoma arising in them,[3] and some authors feel that chronic sinusitis plays a role.[4]

Prolonged local radiation exposure,[5] and occupational exposure to leather[6] and wood dust[7] have been implicated in sinus and nasal fossa carcinomas.

The cases discussed in this report underscore the lack of knowledge about etiology and the importance of early diagnosis in patient survival.

Materials and Methods

The clinical records of patients with histologically proven malignant tumors of the nasal cavity and paranasal sinuses treated at the Milwaukee County General Hospital and the Wood Veterans Administration Hospital from 1958 to 1972 form the basis of this report.

Forty-one cases were reviewed. Those with maxillary sinus tumors were classified retrospectively using Ohngren's classification scheme[8] and the TNM staging system.[9]

The population characteristics were examined. Pathology was categorized according to location, histology, presence of metastases, and second primary tumor. Clinical manifestations and initial diagnoses were listed. Survival for three or more years was correlated with extent of involvement and therapy.

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Results

Population Characteristics—Among the 41 patients, the age at the time of diagnosis ranged from 18 to 82 years, with a mean age of 60.7. The median age was 65, and the peak incidence occurred in the 61 to 70 age group (Table 1).

Males made up 33 of the 41 patients (80%). Thirty-eight of the patients were white (93%).

Suspected predisposing factors were found in only 6 patients. Three had chronic sinusitis for more than 20 years, two had oral-antral fistulas, and one patient had prolonged intracavitary radiation exposure.

Pathology—Thirty-one patients had maxillary sinus cancer. Six patients had primary tumors of the nasal cavity. The other 4 patients had primary carcinoma arising in one of the other sinuses (Table 2).

Thirty-six patients (88%) had squamous cell carcinomas. Single cases of cylindroma, transitional cell carcinoma, schneiderian tumor, reticulum cell sarcoma, and esthesioneuroblastoma were found.

The more well-differentiated tumors were associated with a better prognosis.

Seventeen of 36 patients with squamous cell carcinoma (47%) were found to have metastasis and 16 suffered local recurrence or residual tumor following treatment. Only 7 survived for more than three years.

TABLE 1
Frequency distribution of age at the time of diagnosis

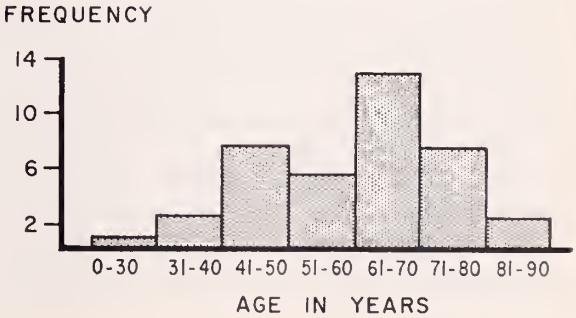

TABLE 2
Location of primary tumor

Site of origin	No. of patients
Maxillary sinus	31 (76%)
Nasal cavity	6 (15%)
Sphenoid sinus	2 (5%)
Ethmoid sinus	1 (2%)
Frontal sinus	1 (2%)

TABLE 3
Presenting symptoms

Symptom	No. of patients
Pain	22 (54%)
Nasal discharge	10 (25%)
Swollen cheek or gum	10 (25%)
Nasal obstruction	6 (15%)
Exophthalmos	3 (7%)
Facial numbness	1 (2%)
Epiphora	1 (2%)
Loose teeth	1 (2%)

TABLE 4
Signs

Finding	No. of patients
Intranasal	
mass or swelling	22 (54%)
epistaxis	3 (7%)
Malar area	
swelling, tenderness, or paresthesia	14 (34%)
Eye	
proptosis or epiphora	3 (7%)
Neck mass	2 (5%)
Trismus	1 (2%)

TABLE 5
Initial diagnosis

Initial impression	No. of patients
Inflammatory or infectious	17
chronic sinusitis	12
osteomyelitis	1
erysipelas	1
foreign body	1
herpes zoster	1
dacryocystitis	1
Neoplasm	21
malignant	14
benign	7
Epistaxis	2

TABLE 6
Ohngren's classification and survival of maxillary sinus lesions

Ohngren's category	No. of patients	Survival
Group 1-a	5	3 (60%)
1-b	0	0
2-a	1	1 (100%)
2-b	2	2 (100%)
3-a	14	2 (14%)
3-b	9	0

TABLE 7
TNM classification and survival of maxillary sinus lesions

TNM Class	No. of patients	Survival
T_1	1	1 (100%)
T_2	5	4 (80%)
T_3	11	2 (18%)
T_4	14	1 (7%)

Nineteen patients had no apparent metastases. Among those who had distant organ involvement, 6 had secondary bone involvement, 5 had lung or pleural involvement, 3 had liver metastases, and single cases of spread to supraclavicular nodes, adrenals, spleen, and kidneys were recorded. Fifteen patients had cervical node metastases.

Six of the patients developed a second primary tumor. Organs involved included the contralateral maxillary sinus, nasopharynx, cecum, prostate, inferior alveolar ridge, and breast.

Clinical Manifestations

Symptoms—The most common complaint was pain in the head and neck region involving the facial, frontal, dental, periorbital, sinus, and mastoid areas.

The next most frequent symptom was serosanguineous or purulent nasal discharge. Swelling of the cheek or alveolar ridge was equally common.

Nasal obstruction and protruding eye were less frequent complaints among this group of patients (Table 3).

An equal number of patients experienced symptoms for less than, or in excess of, six months. The prognosis did not appear to be influenced by duration of symptoms prior to diagnosis.

Signs—Intranasal signs were noted most often. An intranasal mass was the usual presentation. Deviated septum, swollen turbinates, or epistaxis were less common.

Objective findings related to the malar area were next in frequency. Swelling, tenderness, or paresthesia were found.

Signs related to the eye included proptosis or epiphora.

A neck mass was an initial finding in two cases, and one patient had trismus (Table 4).

Initial Diagnosis—The initial impression was often misleading. Only 14 patients were originally thought to have malignancies.

Among these, most were believed to have an inflammatory or infectious process. Chronic sinusitis was the most common initial diagnosis. Osteomyelitis, erysipelas, foreign body, herpes zoster, and dacryocystitis were erroneous impressions in individual patients.

Some patients were diagnosed as having benign tumors such as polyp or mucocele. Others were thought to have primary epistaxis (Table 5).

Classification—The Ohngren classification[8] is based on a "malignancy plane," which divides the antrum into antero-inferior and postero-superior halves. Staging is based on a combination of histology and anatomic location (Table 6). Those patients with tumors that are more well-differentiated and occur antero-inferiorly (groups 1-a and 1-b) have a better prognosis than those with anaplastic lesions located in the postero-superior part of the sinus (groups 3-a and 3-b).

Patients in Ohngren's groups 1-a, 2-a, and 2-b had excellent prognoses, but those in 3-a and 3-b had very poor survival rates.

The TNM classification[9] is based on extent of spread of an antral tumor.

T_1 lesions affect only the anterior, medial, or inferior bony wall. T_2 tumors have invaded the superior or lateral wall but not beyond. T_3

TABLE 8
Results of treatment

Treatment	No. of patients	Survivors 3+ years	Local recurrence
None	2	0	0
Radiation	8	1	3
Chemotherapy	4	0	0
Surgery	4	3	3
Chemotherapy and irradiation	11	0	9
Irradiation followed by surgery	5	3	2
Surgery followed by irradiation	5	1	3
Surgery followed by chemotherapy	1	1	1
Irradiation followed by surgery then chemotherapy	1	0	0

malignancies have penetrated bony walls in any direction with involvement of tissues immediately adjacent to sinus walls. T_4 lesions have extended further, to invade structures not contiguous with sinus walls.

All the patients with tumors in the T_1 and T_2 stages had good survival rates, but those with T_3 lesions were less fortunate. Patients with T_4 tumors had an extremely poor prognosis (Table 7).

The 10 patients with nasal fossa carcinoma or tumor arising in other sinuses were not included in the above classifications.

Treatment—Two patients were not treated because of their moribund condition at the time of diagnosis. Only 1 of 8 patients treated with irradiation alone survived, and 3 had persistent disease.

Chemotherapy with or without radiotherapy was unsuccessful in all 15 patients treated, and nine had local recurrences or residual disease.

Surgery alone or combined with preoperative irradiation or chemotherapy yielded better survival rates than surgery with postoperative irradiation, although patients in all groups had a high incidence of residual tumor or local recurrence (Table 8).

Discussion

The population characteristics of this group of patients agree with reports in the literature[10] except that the sex ratio is more predominantly male. This is expected in view of the much higher percentage of male admissions to veterans' hospitals. The percentage of nonwhite here is somewhat lower than the reported fraction in other series.[10] This statistic may be related to the low nonwhite population in this area.

The location and histologic type of tumor is similar in distribution to those described by others.[11]

Second primary malignancies in patients with head and neck tumors are more common than in the general population.[12] Perhaps the latter reflects a defect in the patient's immune defenses concerned with tumor surveillance.

Unfortunately, most patients have advanced disease when first diagnosed.[13] The series reported here is similar, since 81% (25 of 31) of the patients with maxillary sinus malignancies were in the T_3 or T_4 stage. Early use of x-ray (including tomograms), nasal endoscopy, or exploratory surgery may have yielded diagnosis at a more favorable stage.

The survival rates of patients with T_1 and T_2 lesions of the maxillary sinus agree with the findings of Sisson,[9] and those of Schechter and Ogura.[13] Only 2 of the 11 patients with T_3 tumors survived three years. This was disappointing in view of previous reports[9,13] of about 50% survival among patients at this stage. Perhaps some of those patients included in this group in this series actually had T_4 tumors. It is sometimes very difficult to determine the extent of tumor spread.

The treatment may have been inappropriate in certain cases. It is recognized[13] that an aggressive approach to advanced tumors is required to achieve patient survival and minimize recurrent or residual tumor. Eight patients were treated with irradiation alone, four received only chemotherapy, and eleven received chemotherapy in addition to irradiation.

Although chemotherapy is said to potentiate the tumoricidal effects of irradiation,[14,15] survival may not be prolonged by the combination[16] unless adequate surgical treatment is added. Perhaps the latter reduces the bulk of neoplastic cells to a number that can be effectively dealt with by the patient's immune system.

Patients with advanced tumors may have a poor prognosis, but authors have exhorted head and neck surgeons not to forget the value of palliative measures in improving the quality of the patient's survival.

Summary

This study describes the population charactertistics, pathologic data, and clinical manifestations of malignancies of the nasal cavity and paranasal sinuses in 41 patients. Patients with maxillary sinus malignancies are classified retrospectively with Ohngren's and the TNM classification, and the effects of stage and treatment on survival are discussed.

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"Those of us privileged to have had direct benefit from the man who so well lived up to his given name, JOSEPH, are indeed grateful. We have been filled with admiration and inspired by your personification of all that the title DOCTOR conveys."
—P. M. Wilkinson, MD, Oconomowoc

"You have represented an ideal to me which I hope can be passed on to many other individuals. Eulogies to you will be left to others more versed but I can only add my gratitude to your inspirational leadership in medicine, in family love and in compassion to our fellow men who come to you as 'patients.'"
—Oliver H. Whetstone, MD, Kenosha

"My first encounter with this magnificent man was one of trepidation and unsurety. The quality of a hard exterior concealed something uniquely human and almost paternalistically tender. In particular, as an American-trained, foreign-born resident on his service, the deep concern, warmth, yet firmness in his approaches heightened the quintessence of a man, who brought out the best in all of us. Dr. King was awesome in his capacity to invoke confidence and devotion from his residents. For me, it was a unique privilege to be under his guidance. I was particularly struck by the personal interest he more than once demonstrated in me in how I was getting along as a 'bachelor' resident! Such a man, rare indeed, must have been a godsend to those of us who now carry his mark in our souls and in our hearts. Long live the King!"
—Azeez Bacchus, MD, FACS, Lancaster, Ca.

"I remember Doctor Joseph M. King as a physician, humanitarian, teacher, and friend. His judgment as to when to use a knife was second to none. He taught his residents compassion and to respect the indigent. He often stated 'without the poor a surgeon cannot be properly trained.' He often reminded us our surgical skill and practice depended on training provided by the poor at Milwaukee County General Hospital. He had no difficulty separating good medicine and good morals, to him there was never a difference. He would not excuse surgery done for experience of a resident alone, it had to be for the benefit of the patient and must have true surgical indications. Doctor King also taught professional appearance and standards. Neatness and cleanliness were a must and smoking in a patient area was cause for a tornado reaction. I was fired at least 21 times in three years for cigarette smoking."
—Richard T. Flynn, MD, Wood

"By my third year residency, I began to lose my fear of "the boss." I began to mature and found that surgery was a good deal more than quoting the literature, surgical techniques, etc. You taught me how to take a history — which I should have learned years before. You taught me how to examine a patient, you taught me about all, the art of medicine — how to be compassionate regardless of circumstances. When I finished my fifth year of residency, I felt as though I had the finest technical experience on handling surgical problems plus the added experience of having been associated with a gentleman of fine character, love, devotion, and honesty."
—Jack F. Murray, MD, Monroe

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Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

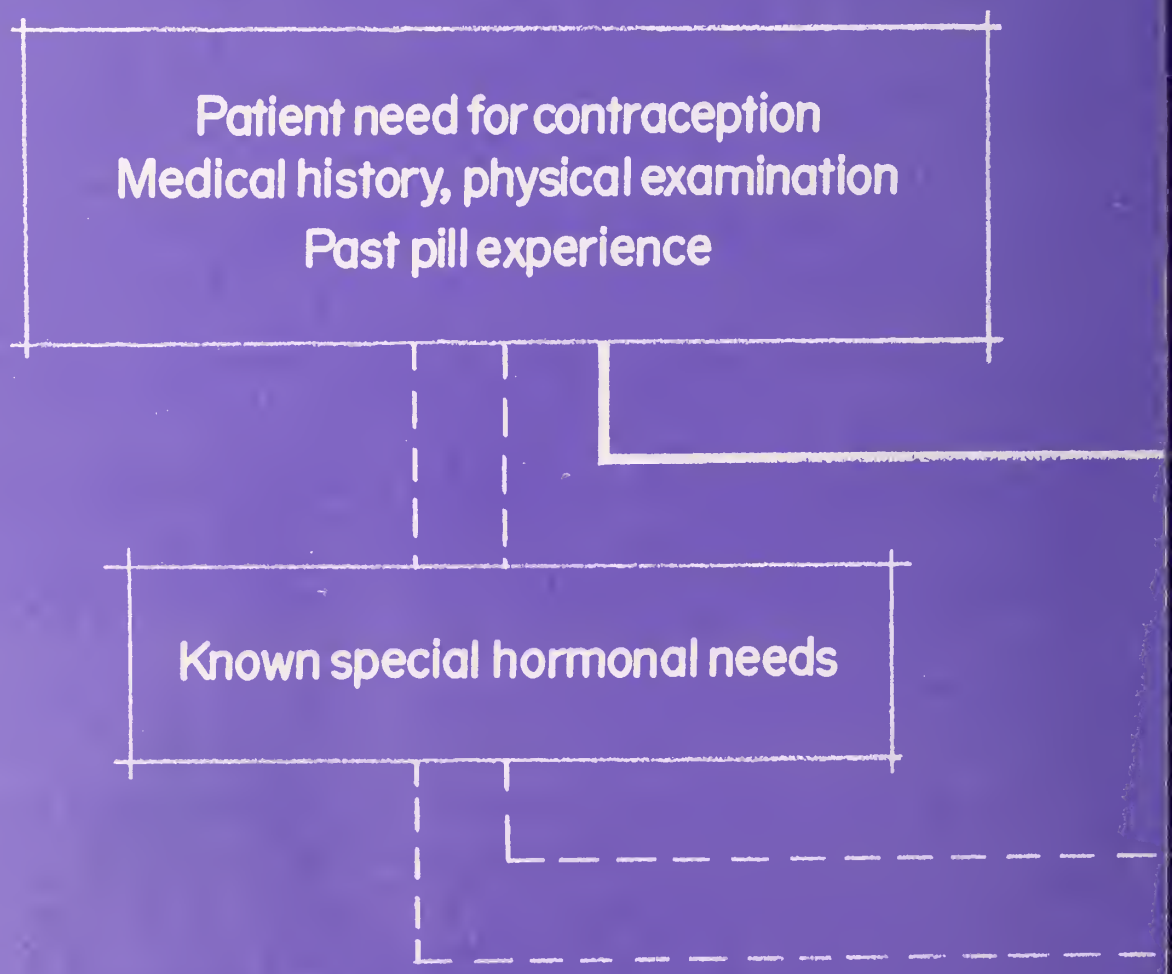
Supplied: Bottles of 50 capsules.

SK&F *Smith Kline & French Laboratories*

How to better achieve a smooth "pill" response :

A blueprint for introducin

1. If one "pill" were right for every woman, we'd make it.



he pill" to your patient

. Demulen, a 50-mcg. "low-estrogen" pill, is a logical first choice.

3. If your patient requires a different hormonal balance temporarily or for the long term— Searle offers you alternatives

For a "standard" 50-mcg. start

Demulen®

Available in 21- and 28-pill schedules. Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg. Each pink tablet in Demulen-28® is a placebo, containing no active ingredients.

A moderately progestogen-dominant combination with low estrogenic activity.*

SEARLE Product of Searle & Co. San Juan, Puerto Rico 00936

When slightly more estrogenic activity is indicated

Ovulen®

Available in 20-, 21- and 28-pill schedules. Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg. Each pink tablet in Ovulen-28® is a placebo containing no active ingredients.

A centrally balanced estrogen/progestogen combination.*

SEARLE Product of Searle & Co. San Juan, Puerto Rico 00936

For the woman who clearly needs more estrogen or is sensitive to other progestogens

Enovid-E®

Available in 20- and 21-pill schedules. Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

An estrogen-dominant combination with no androgenic activity.*

SEARLE Product of Searle Laboratories Division of G. D. Searle & Co. Box 5110, Chicago, Illinois 60680 *Where "The Pill" Began*

*Primarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information. For brief summary of prescribing information, please see next page.

If one "pill" were right for every woman, we'd make it.

Ovulen® **Available in 20-, 21- and 28-pill schedules**
Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.
Each pink tablet in Ovulen-28® is a placebo, containing no active ingredients.

Demulen® **Available in 21- and 28-pill schedules**
Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Demulen-28® is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

SEARLE Products of **Searle & Co.**
San Juan, Puerto Rico 00936

Enovid-E® **Now available in the 21-pill schedule in refillable Compack® and three-cycle Triopak™**
Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

Enovid-E®
brand of norethynodrel with mestranol

SEARLE Product of **Searle Laboratories**
Division of G. D. Searle & Co.
Box 5110, Chicago, Illinois 60680
Where "The Pill" Began

STATE MEDICAL SOCIETY OF WISCONSIN

Medical GREEN SHEET

WISCONSIN MEDICAL JOURNAL VOL. 72, No. 12 DECEMBER 1973

FROM THE PRESIDENT

Santa's Gifts for Wisconsin Doctors

1. Multiple PSROs wrapped in red tape.
2. A statewide public health utility, sugar-coated.
3. A certificate of need law including doctors' offices.
4. Many large-sized "malpractice suits" resulting from above.

Happy Holidays!

G. J. Derus M.D.

P.S. For a happier new year, wish your legislator a happy holiday season—and be involved—reelection is next fall.

MEDICAID

Getting a Toehold

One of life's more frustrating jobs is trying to get a toehold on a new government program. A case in point is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, a new wrinkle under Medicaid.

Part of the problem in Wisconsin may be that three levels of government are involved. After receiving guidelines from the federal government, the state government is working through county governments to get the actual work done.

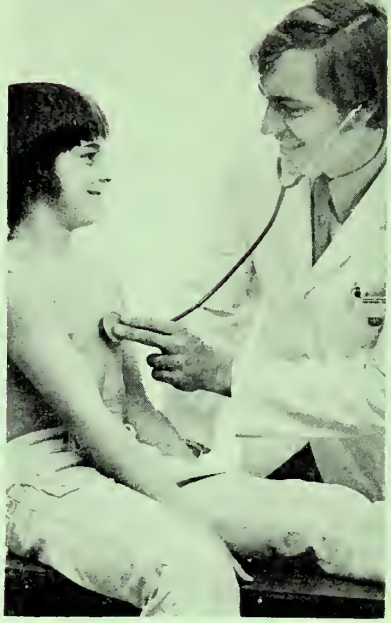
However, what is frustrating some state physicians is learning what the screening will include and how it will be done. EPSDT is designed as health screening for all Medicaid eligible children under age 21. It is being set up under time pressures, for if it is not underway by next July the state stands to lose close to one million dollars in federal Aid to Financially Dependent Children (AFDC).

Government, Private Cooperation

The Dane County Medical Society, the State Medical Society of Wisconsin, the Wisconsin Chapter of the American Academy of Pediatrics, and the Wisconsin Academy of Family Physicians have urged the state to use both public health departments and private physicians in the program. They have proposed physician exams until the child reaches age two, with return visits for complete physicals when the child starts school, at age nine and at the onset of adolescence. Between these visits the county public health department would do periodic screening at a local center and send the physician any positive findings. The Dane County physicians argue that this system would keep cost at a minimum for a high level of medical care.

Minimal Cost, High Level Care

One physician closely involved in developing this idea is a member of a committee named by the State Medical Society some months ago to work with the Division of Health in setting up EPSDT. Conrad L. Andringa, MD, Madison, urged members of the Society's Division on Maternal and Child Welfare at its November 9 meeting to adopt this plan because it could work not only for EPSDT but also play an important role in the future medical care of all Wisconsin children. This would result because



EPSDT

What is "screening" and who will do it?

guidelines would be developed on such things as when screening should be done, when the child should see a physician, and what tests should be done at what age.

Another member of the committee, C. R. Weatherhogg, MD, Madison, told the Division that a problem is lack of time. Four or five counties have already signed contracts for the project and some 20 more have contracts in draft form. Dane County has completed a pilot screening project done by nurses. Literature distributed during the project did not mention the fact that the screening can be done by any licensed physician. (New literature will be changed to say this.)

County Level Initiation

To get the program started, the state is allowing each county to more or less decide for itself what sort of screening program it will operate. However, no start up money has been provided by the state. After the entire program is underway, state officials then believe the federal and state governments will set a uniform program for the entire state.

Dr. Weatherhogg and others have urged the state government to have a policy-making committee for EPSDT which includes physicians. To date this has not been done.

The Society's Division on Maternal and Child Welfare approved a statement at its meeting which recommends that county medical societies make themselves available to act in an advisory capacity to EPSDT as it is initiated in each Wisconsin county. Physicians involved with this project urge physicians throughout the state to accept positions on county health department boards or to arrange to act advisory to those boards to guarantee a medically sound program. □

WHCRI

Taking Another Step

Another step was taken last month in the development of Wisconsin Health Care Review, Inc. (WHCRI). WHCRI was the sponsor for a meeting November 20 at which leading Wisconsin health insurance executives took tentative steps toward the formation of a Health Insurance Advisory Committee to assist WHCRI. Attendees at the meeting at State Medical Society headquarters in Madison included representatives of seven insurance companies as well as review foundations and associations for state physicians, dentists, hospitals and health, life and casualty insurers.

Until now, WHCRI's work has been to review care paid for with public funds. It has had two contracts to review the medical care received by Medicaid patients. One was at the state colonies; the other involved Wisconsin nursing home patients.

However, review of health care services is not unique to government programs. As a result, insurance carriers have shown increasing interest in this area. They see WHCRI as an impartial outside review agency which will assure the industry and public of uniform, non-duplicative, multi-disciplinary review structures functioning throughout the state. In turn, WHCRI will require cooperation and technical capabilities from the insurance industry to assure the coordination and support of local review.

At the end of the meeting, five members of the group were named to plan the Health Insurance Advisory Committee. They are: Carroll Lewis, president, Time Insurance Company; Robert Haskins, vice-president of Professional Relations, Blue Cross of Wisconsin; Jacob Spies, assistant vice-president, Health Systems, Employers Insurance of Wausau; Ray Koenig, executive director, Wisconsin Physicians Service (WPS); and, John McComb, vice-president, Claims, Sentry Insurance Company. □

Skylab: Clinic in Orbit

"We were healthier and happier in space than we thought we would be."

According to Navy Capt. Joseph P. Kerwin, who became America's first physician-astronaut during the 28-day orbit of Skylab 1, this was one of the findings from experiments conducted in space.

Capt. Kerwin, a 41-year-old flight surgeon who has been an astronaut since 1965, appears in The Network for Continuing Medical Education (NCME) telecast: "Skylab: Clinic in Orbit," beginning December 31 and continuing through January 13 at 19 Wisconsin hospitals.

During these two weeks two other NCME programs are also scheduled: "The Exercise Prescription" and "Office Tests to Confirm Chronic Obstructive Lung Disease."

Beginning in January, the *Wisconsin Medical Journal's* "Medical Yellow Pages" will regularly list upcoming medical education programs distributed by NCME.

Participating Wisconsin hospitals are: Appleton — St. Elizabeth's; Green Bay — Bellin Memorial; Kenosha — Kenosha Memorial; Madison — Madison General, Mendota State, and University Hospitals; Manitowoc — Holy Family; Milwaukee — Deaconess, Milwaukee County, Mt. Sinai, St. Francis, St. Luke's, St. Michael, and Veterans Administration (Wood); Oconomowoc — Memorial; Racine — St. Luke's; Sheboygan — St. Nicholas and Sheboygan Memorial; Waukesha — Waukesha Memorial. □

SMS Committees *in action*

"Medical Necessity." Council's Committee on Peer Review's Subcommittee on Quality Standards,* August 23, agreed that most peer review (about 80%) is cost oriented and the committee believes that this much emphasis would be more properly put on assessing the quality of care. Subcommittee also adopted a resolution stating that it is inappropriate to use physician profile data based on gross statistical averages as the primary factor in determining either "medical necessity" or quality. This inappropriate practice has been developed by the Social Security Administration.

Review Criteria and Guidelines. Subcommittee on Quality Standards, October 21, agreed that there should be maximum "grass roots" involvement in developing (or adopting) review guidelines and acceptable practice pattern criteria. There also was consensus that, in view of existing criteria developed by others, it would be futile for the committee to duplicate these efforts.

To accomplish the widespread involvement of members of the profession it was agreed to contact existing foundations and the chiefs-of-staff of several representative hospitals to request the criteria they use for evaluation of inpatient practice. This information would be sought with respect to the 20 clinical entities which are the most frequent causes for hospital admission. All the specialty societies will be asked for such criteria on the 10 entities for each specialty which are the most frequent reasons for hospitalization. Specialty societies also are to be contacted to ascertain how they wished to formally participate in the review processes on a coordinated basis.

Peer Review and Educational Programs. Subcommittee on Quality Standards, October 21, agreed that the Committee on Peer Review would be responsible for review guidelines, practice pattern criteria, peer review and related concerns. To the extent these activities identify needs for education programs, such needs will be reported to the Commission on Scientific Medicine for indicated follow-up.

NOTE: Members of this subcommittee are MDs: F. N. Lohrenz, Marshfield, chairman; R. W. Edwards, Richland Center; D. R. Griffith, Eau Claire; Rocco Latorraca, Wauwatosa; T. M. O'Connor, Milwaukee; W. L. Treacy, Milwaukee; R. F. Douglas, Neenah; and E. O. Hirsch, Milwaukee. Arthur E. Angove, DO, is liaison representative with the Wisconsin Association of Osteopathic Physicians and Surgeons. □

70-Year-Old Doctors Get Break in Dues

The Society reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classification can be arranged.

The Fragile Mind

"The Fragile Mind," an hour-long special narrated by Academy Award-winning actress Joanne Woodward on ABC-TV Wednesday, Jan. 9, 9:00 PM, deals with a problem which touches one of every four American families and one of every ten persons—mental health.

The program shows how five people faced their problems and how they were helped toward recovery. Wisconsin stations carrying the program are: Channel 27, Madison; Channel 19, La Crosse; Channel 9, Wausau; Channel 11, Green Bay; and Channel 6, Milwaukee. □

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EDITOR: Carol Dovenport, Public Information Director, State Medical Society of Wisconsin.

Alert to Members!

DEADLINES

for 1974

ANNUAL MEETING

Events

January 24
Resolutions for the House of Delegates due in Secretary's office (two months before First Session)

If resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS Staff will assist in preparation of fiscal notes.

February
Early publication of the *Wisconsin Medical Journal* with inclusion of major portions of the Annual Meeting program and summaries of the resolutions

March 23
Council meeting

March 24, 25, 26
House of Delegates sessions

March 25, 26
Scientific Program

REPRINT

2—THE CAPITAL TIMES, Thursday, November 15, 1973

Health Maintenance Plan Gets Go-ahead

Dane County physicians have given the go-ahead to continue the Wisconsin Physicians Service health maintenance program (HMP) for two more years.

Approval by the county medical society came after its officers and WPS officials reported the program is moving toward financial success.

Fourteen groups covering 14,000 employes are now covered by the HMP plan which provides prepaid insurance for doctors' office calls and reduced charges for drugs.

Dr. Blake Waterhouse, president of the Dane County Medical Society, said that the HMP plan provides 20 per cent more in services because of decreased hospitalization and elimination of billing costs and bad debts.

"It affirms the belief we had that members are not only interested in bettering health care, but are anxious to work out a system of savings which they can pass along to patients in terms of expanded services," Dr. Waterhouse said.

The two-year extension of the HMP plan received "overwhelming support."

A WPS spokesman said the Dane County plan has attracted national attention.

Claims Manager William Schweers said the program started to break even after the first six months of operation. WPS officials had expected some losses at the outset because any change in an insurance program tends to increase use at the outset.

Under the plan an individual chooses a primary physician who receives a certain monthly amount for health care coverage.

Only 13 of the county's 554 private physicians have refused to participate in the program, according to the spokesman.

Among the major groups covered by the HMP program are Dane County employes, City of Madison employes, non-teaching employes of the Madison Board of Education, Madison Area Technical College employes, employes of the National Mutual Benefit Life Insurance Co., Oregon school employes, workers at Madison Newspapers Inc., and employes of the First National Banks of Wisconsin.

The plan also covers costs beyond the first $2 for each prescription.

Schweers said that over-utilization of services, feared by some physicians, failed to materialize in the first year.

Wisconsin Physicians Services called major clinics and doctor offices before the issue was taken back to the Medical Society.

A spokesman for WPS said it would take at least another year to provide statistical data to carefully analyze the program for possible flaws.

The Health Maintenance plan is different from Health Maintenance Organization (HMO) operating in other parts of the country. In the HMO plans the persons involved have only a limited selection of physicians.

"In our plan the individual picks his own doctor. The patient-physician relationship is continued, as well as the referral system. There's no start-up money, no federal funding, no land to buy, or hospitals or clinics to build," said Schweers.

NEWS HIGHLIGHTS

Wisconsin Radiological Society Has Elections

The Wisconsin Radiological Society at its 24th annual meeting in Madison in September elected the following officers: president, Robert Douglas, MD,* Neenah; president-elect, John Swingle, MD,* La Crosse; vice-president, Ralph Kennedy, MD,* Appleton; and secretary-treasurer, Marvin Hinke, MD,* Marshfield.

Wisconsin Society of Neurological Surgeons Ratifies Constitution

At an organizational meeting of the Wisconsin Society of Neurological Surgeons held in September in La Crosse, 18 neurological surgeons from throughout the State of Wisconsin reviewed and approved a proposed constitution. The preamble of the constitution states that the purpose of the organization is to improve the delivery of health care particularly as it relates to neurological surgery; represent neurosurgery in liaison with state health agencies, state medical societies, governmental health agencies, and other professional societies; disseminate knowledge to the public relating to neurosurgery; enhance the quality of neurological surgery in the State of Wisconsin, and to hold meetings for the exchange of scientific information in matters professional, technical, and ethical. Election of officers, held at this meeting, was reported in the October issue. Sanford Larson, MD* of Milwaukee was elected an Executive Committee member. Since this meeting, 27 of the state's neurosurgeons have become charter members of the new society.

Doctor Riegel, St. Croix Falls, Honored

J. A. Riegel, MD* longtime physician at St. Croix Falls, is shown standing with his wife, Florence, and son, Fred Reigel, MD* by the new flag pole dedicated in his honor. Doctor Jake was presented with a color photograph showing the bronze plaque and flag pole. The inscription reads: "Dr. J. A. Riegel, given by his colleagues and friends in recognition of his long years of service to the health of the community." (Photo courtesy THE POLK COUNTY LEDGER — Balsam Lake)

PHYSICIAN BRIEFS

Raymond M. Baldwin, MD*

. . . Beloit, in October was greeted by Mrs. Richard Nixon at a White House reception for the American Association of Medical Assistants. During the group's annual convention in San Diego, Calif., Doctor Baldwin was awarded a Meritorious Service Award. He is a physician-advisor to the AAMA. (Photo courtesy BELOIT DAILY NEWS)

Dr. Baldwin and Mrs. Nixon

William F. Schorr, MD*

. . . dermatologist at the Marshfield Clinic and president of the Marshfield Clinic Foundation for Medical Research and Education, was elected president of the Minnesota Dermatologic Society at a meeting of the group in mid-November in Minneapolis. In 1971 Doctor Schorr was vice-president of the 168-member Minnesota group and later served as president of the Wisconsin Dermatologic Society. He served as vice-president of the Wisconsin group in 1970.

Serafino S. Maducdoc, Jr., MD

. . . Mayville, recently became associated with the Marshland Medical Clinic Association, Ltd. Doctor Maducdoc graduated from the Manila Central University, Philippines, in 1963 and took his internship followed by three years of general surgery residency at Mercy-Timken Mercy Hospitals, Canton, Ohio. Prior to coming to Wisconsin, Doctor Maducdoc practiced in West Virginia.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

CHRISTMAS....

. . . time to give thanks for the good things in life. Time to say thanks to those who make wishes and dreams come true. Time to say "I love you" in the best possible way.

E. W. Parker
JEWELERS
On The Square Since 1857 251-2331

Madison's Oldest
. . . Most Trusted
Diamond Counselors

PHYSICIAN BRIEFS . . .

Howard G. Bayley, MD*

. . . Beaver Dam, was commended recently by the Board of Directors of the Wisconsin Radiological Society for his 13 years of service to the society as a member of the board, secretary-treasurer, president, and most recently as counselor. Doctor Bayley recently completed a six-year term as councilor to the American College of Radiology and was succeeded in this post by James Youker, MD* of Milwaukee.

Louis F. Warrick, Jr., MD*

. . . Madison, was recently elected president of the medical staff of Methodist Hospital in Madison. He succeeds Howard W. Mahaffey, MD* who had been president for two years.

F. W. Reichardt, MD*

. . . Stevens Point orthopedic surgeon, recently returned from a two-month tour of duty aboard the USS HOPE, a privately funded hospital ship which seeks to improve medical care in underdeveloped areas of the world. The voluntary tour took him to Maceio, Brazil, where he and about 25 other medical specialists worked with indigent patients and carried on a program of education in updating medical practice and teaching. Doctor Reichardt was a similar volunteer several years ago in a mission to the Dominican Republic.

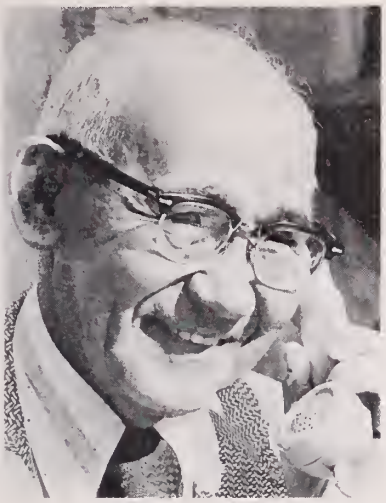
David J. Carlson, MD*

. . . Wauwatosa, was elected president of the Milwaukee Division of the American Cancer Society at its annual meeting October 24 at the University Club of Milwaukee. He is director of laboratories at St. Mary's Hospital and past president of the Medical Society of Milwaukee County.

Ilhan S. Adali, MD*

. . . Milwaukee, recently became associated with the South Milwaukee Clinic. Doctor Adali completed his medical education at the University of Istanbul, Turkey, and served his internship at Milwaukee County General Hospital. His residency in obstetrics and gynecology was completed at Mt. Sinai Hospital, Milwaukee, and Regina General Hospital, Canada. Doctor Adali is a member of both Trinity Memorial Hospital and Mt. Sinai Hospital in Milwaukee.

PHYSICIAN BRIEFS . . .



Doctor Milson

Louis Milson, MD*

. . . at 75 years of age is still practicing medicine in Green Bay, although at a reduced pace. He recently was featured in the *Green Bay Press-Gazette* which delved into his childhood memories of a Russian native of Jewish faith immigrating to the United States at the age of 16 to fulfill a dream of becoming a doctor. This he accomplished in 1924 when he graduated from Marquette Medical School in Milwaukee. He later set up his practice in Green Bay where he has remained and plans on celebrating his 50 years of practice in 1976. (GREEN BAY PRESS-GAZETTE Photo)

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NEWS HIGHLIGHTS . . .

American College of Surgeons Honors 24 Wisconsin Physicians

The American College of Surgeons recently held its 59th Annual Clinical Congress in Chicago, Ill. The largest number of surgeons in the history of the College were inducted as new Fellows during the five-day Clinical Congress of which twenty-four physicians were from Wisconsin and are as follows: MDs R. H. Ward,* Appleton; Senekerim Armagan,* Cudahy; Bruce C. Bayley, Eau Claire; Benedict E. Liewen,* Fond du Lac; Carl F. Schmidt* and John J. Smalley,* La Crosse; P. S. Chopra,* Thomas D. France,* J. T. Hassinger,* Laszlo Kaveggia,* and Andrew A. McBeath,* Madison; S. K. Bhattacharyya,* Charles P. Floyd,* Marshfield; J. P. Hogan,* S. Fredric Horwitz,* A. W. Howell,* G. L. Schmitz,* Milwaukee; C. H. Ozturk,* Neillsville; R. E. Buck,* Lyall C. Stilp, II,* Oshkosh; D. F. Cohill,* R. F. Siegert,* Racine; R. J. Darling,* Waukesha; and R. A. Kloehn* of Wauwatosa.

Doctor Ravn Heads Cancer Society's Wisconsin Division

Erling Ravn, MD* of Merrill was elected president of the Wisconsin Division of the American Cancer Society at its annual meeting for volunteers from the 70 units on October 19-20 at the Pioneer Inn, Oshkosh. He served as first vice-president of the Wisconsin Division and as chairman for the public education committee. The Merrill physician-surgeon is medical director for the 12-county area in North Central Wisconsin. An Ellsworth physician, Eugene R. Jonas, MD* was elected first vice-president. Medical directors reelected were Glenn A. Smiley, MD,* Delavan, and Gail Williams, MD,* Marshfield.

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PHYSICIAN BRIEFS . . .

Margaret J. Prouty, MD*

. . . chief of pediatrics at Methodist Hospital and the Jackson Clinic, Madison, recently received an Alumni Achievement Award from Nebraska Wesleyan University, Lincoln, Neb. Doctor Prouty graduated from the university in 1932.

Hubert V. Moss, MD*

. . . Madison, recently was elected president of the Wisconsin Dermatological Society. Doctor Moss is associated with the Jackson Clinic and is a clinical assistant professor at the University of Wisconsin Medical School in Madison. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1973

- 2 Executive Committee of SMS Council
- 3 Finance Committee, Planning Committee, and Committee on Economic Medicine of SMS Council
- 3 Nominating Committee of SMS House of Delegates
- 3 AMA Delegation Caucus
- 3 SMS Council
- 4 Annual Meeting of SMS Realty Corporation
- 4 SMS Council
- 5 Madison Surgical Society
- 6 Madison Anesthesiology Society
- 6 Madison Urological Society
- 6 Dane County Medical Society Board of Trustees
- 8 SMS Committee on Medicine and Religion
- 8 Madison Academy of Internal Medicine
- 8 Professional Nurse Exams
- 9 SMS Division on Maternal and Child Welfare
- 9 Professional Nurse Exams
- 13 Dane County Medical Society
- 14 Executive and Legislative Committees, SMS Section on Ophthalmology
- 15 Executive Committee, Board of Trustees of CES Foundation
- 20 Wisconsin Health Care Review, Inc.
- 28 SMS Division on Handicapped Children
- 28 Ad Hoc Committee, SMS Commission on Scientific Medicine
- 30 Conference on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parenthesis.

NEWS HIGHLIGHTS . . .

Dean Magnin, MD,* Marinette, was newly elected as an area medical director. Medical directors-at-large reelected were Ralph C. Frank, MD,* Eau Claire; Robert Johnson, DO, Appleton; and Arthur L. Van Duser, MD,* Madison. Henry Pitot, MD,* Madison, was newly elected medical director-at-large. John K. Scott, MD,* Madison, was elected delegate to the National Society to serve the 1974-1976 term.

New Scholarship Fund for Medical Students

The Medical College of Wisconsin recently announced the establishment of a new scholarship fund for medical students, given by Madison radiologist, O. Arthur Stiennon, Jr., MD* in honor of his father, O. A. Stiennon, MD* of Green Bay. The 82-year-old Green Bay physician is one of the Medical College's oldest living graduates. The scholarship will provide $500 a year to a needy student. The senior Doctor Stiennon graduated in 1918 from the medical college and entered practice in Green Bay 54 years ago. With his presentation of the gift, Doctor Stiennon expressed the importance of honoring his father while he is still practicing medicine and his gratitude to the college for the education of his father and his son, O. A. Stiennon, III, MD who graduated from the college in June 1973. Doctor Stiennon, Jr. is a graduate of the University of Wisconsin Medical School.

Physicians Honored for Service to Medical Society

A former Wausau family practitioner and a Marshfield surgeon were honored by their colleagues in the Ninth Councilor District of the State Medical Society of Wisconsin at a Wausau meeting in late October. Ervin P. Ludwig, MD,* who retired from the Wausau Medical Center in 1971, and Robert W. Mason, MD* a Marshfield Clinic orthopedic surgeon, received plaques for their service to the State Society and its Councilor District. The awards were presented by Earl R. Thayer, secretary of the State Medical Society. Both doctors served six-year terms on the Society's Council. Doctor Mason also served on the Society's Grievance Committee. The gathering of about 65 physicians from eight central Wisconsin counties also heard Robert E. Cooke, MD, vice-chancellor of health sciences at the University of Wisconsin-Madison, discuss issues associated with the new health occupation—physician assistant. Pictured are, from left: Doctor Cooke, Doctor Mason, Doctor Ludwig, Mr. Thayer, and James F. Bigalow, MD* of Merrill, president of the Ninth Councilor District. (Photo courtesy WAUSAU RECORD-HERALD) □

when manhood ebbs...
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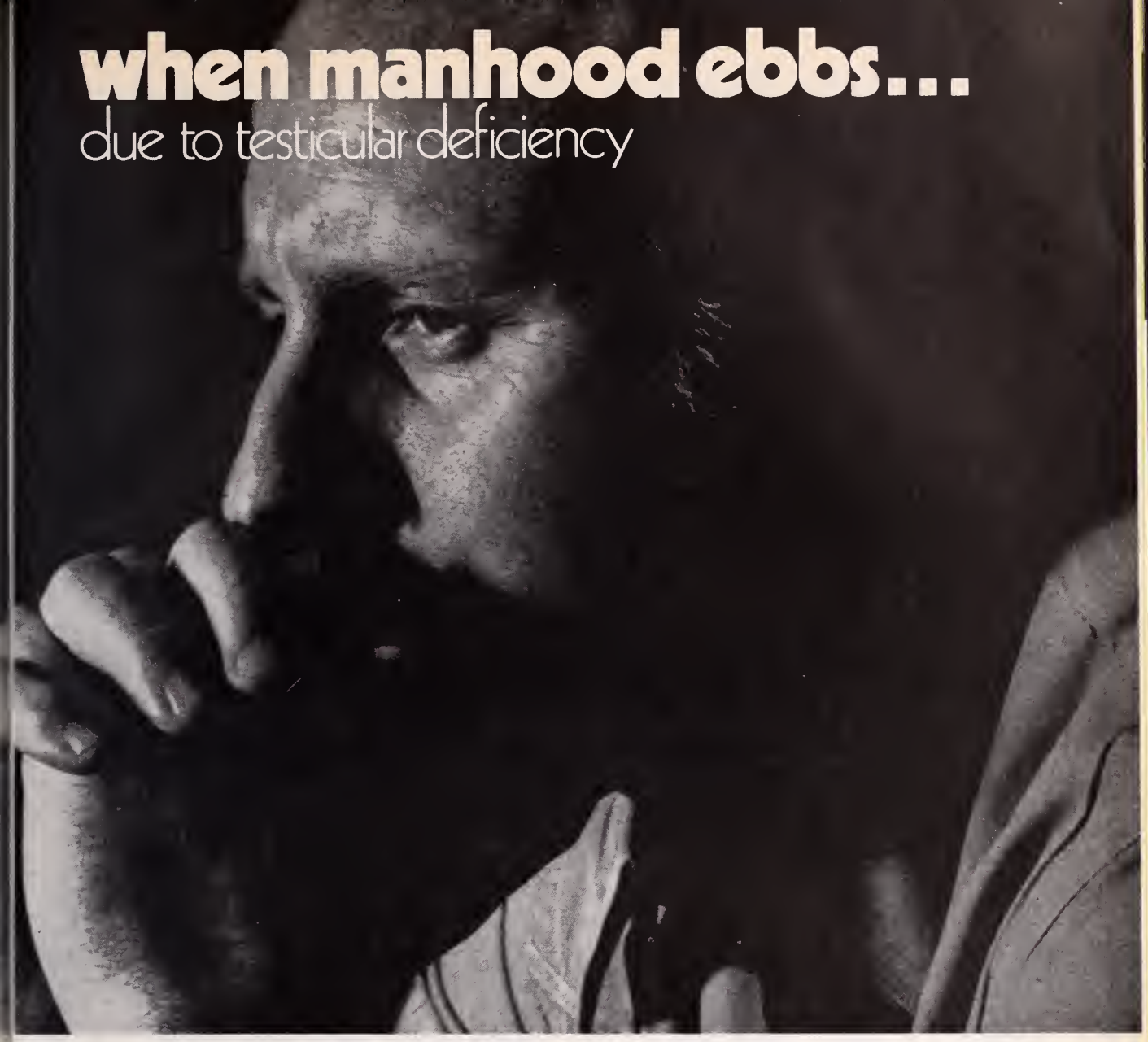

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Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13. Beeson, P. B. and McDermott, W. eds. Philadelphia, W. B. Saunders Co., 1971, p. 1816.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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OBITUARIES

Franklin A. Kordecki, MD, 54, Manitowoc, died May 20, 1973 in Manitowoc.

Born on Sept. 30, 1918 in North Chicago, Ill., Doctor Kordecki graduated from Marquette University School of Medicine in 1943 and served his internship and residency training at West Suburban Hospital, Oak Park, Ill., and Cook County Hospital in Chicago. He served in the United States Army Medical Corps during World War II. Doctor Kordecki also received psychiatric training at Winnebago State Hospital and at Mental Health Institute at the University of Iowa. He settled in Manitowoc in 1964 and was associated with Holy Family Hospital, Memorial Hospital, Two Rivers Municipal Hospital, and the Manitowoc Mental Health Center.

He was a member of the Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; a son, Greg, of Atlanta, Ga.; and three daughters, Cynthia, Lesley and Collette, at home.

Fred H. Garbisch, MD, 68, Antigo physician and city health officer, died June 28, 1973 in Antigo.

Born on Oct. 14, 1904 in Stratford, Wis., Doctor Garbisch graduated from Marquette University School of Medicine in 1943 and interned at Columbia Hospital, Milwaukee. Prior to receiving his medical degree, Doctor Garbisch had practiced dentistry in Antigo for 10 years. He had been a member of the Wisconsin National Guard for three years and in the United States Army Reserve from 1933 until 1944 when he entered active military service for three years.

Doctor Garbisch was a member of the American Association of Railway Surgeons, and was the examining and attending physician for the Chicago and Northwestern Railway.

He was a member of Langlade County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Loretta, and a son, William, of Mequon.

Edyth C. Swarthout, MD, 81, prominent La Crosse physician for many years, died Sept. 10, 1973 in West Salem.

Born on Nov. 8, 1891 in La Crosse, Doctor Swarthout graduated from Johns Hopkins University in 1919 and served her internship at Bellevue Hospital in New York. After completing her internship in 1922, she joined her father, Ezekiel Chester Swarthout, MD in practice. Although confined to a wheel chair after an automobile accident in 1953, Doctor Swarthout continued her practice of medicine and in 1972 was honored by the community for her 50 years of service.

She became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1969 and also was a member of the La Crosse County Medical Society and American Medical Association.

There are no immediate survivors.

Volney B. Hyslop, MD, 76, prominent Milwaukee plastic surgeon, died Sept. 13, 1973 in Hayward, Wis.

Born on Sept. 30, 1896 in LaValle, Wis., Doctor Hyslop graduated from Washington University Medical School in 1924 and served his internship at St. Mary's Hospital in Madison. His residency was completed at University Hospitals, Madison. Doctor Hyslop taught at the University of Wisconsin Medical School from 1929-1944 and also was in private practice in Madison until 1951 when he moved to Milwaukee. He was an emeritus clinical professor of plastic and reconstructive surgery at Marquette University School of Medicine and in 1966 and 1970 received the "Distinguished Service Award" of the Cosmopolitan Club of Milwaukee.

Doctor Hyslop served on the medical staffs of Milwaukee County General, St. Mary's, West Allis Memorial, Milwaukee Children's, St. Anthony's, and Hayward Municipal hospitals. He was a Fellow of the American College of Surgeons, and a member of the American Society of Plastic and Reconstructive Surgery, American Association of Plastic Surgeons, and the Wisconsin Society of Plastic Surgeons.

He also was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, Donald K., of Pewaukee.

Aubrey H. Pember, MD, 78, prominent Janesville physician for many years, died Sept. 29, 1973 in Winter Park, Fla.

Born on Oct. 7, 1894 in Janesville, Doctor Pember graduated from Northwestern University Medical School in 1918 and served his internship and residency in Augustana and Cook County hospitals. He was an associate in ophthalmology at Northwestern University for eight years. He became affiliated with the Pember-Nuzum Clinic (now the Riverview Clinic) cofounded by his father, Dr. John F. Pember, specializing in diseases and disorders of the eye, ear, nose, and throat. He retired in 1957 and had been living in Florida for the past sixteen years. He was a member of the "Fifty Year Club" of the State Medical Society of Wisconsin, a member of the American Academy of Ophthalmology and Otolaryngology and also a Fellow of the American College of Surgeons. He was a member of the medical staff of Mercy Hospital in Janesville. Doctor Pember also was one of the original founders of "The Great Masterpiece" in Lake Wales, Fla.

Pember

He was a member of the Rock County Medical Society and American Medical Association.

Surviving are his widow, Bennett, Winter Park, Fla.; two sons, Dr. John Pember, Janesville, and Charles, Bellevue, Wash.; and one daughter, Mrs. Dudley Godfrey, Milwaukee.

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Barrett, James L., 1813 West Luther Rd., Janesville 53545
Bolich, Paul R., 6713 Spring Grove Court, Middleton 53562
Brandt, William N., P. O. Box 551, Janesville 53545
Brannen, Charles H., P. O. Box 427, Menomonee Falls 53051
Brault, Robert G., 1551 Dousman St., Green Bay 54303
Brown, Ronald R., 1821 South Webster Ave., Green Bay 54301
Buencamino, Ernesto E., 3618-8th Ave., Kenosha 53140
Doss, Jerry C., 1209 Commercial, Neenah 54956
Fink, Richard A., 1836 South Ave., La Crosse 54601
Fossum, Dale R., 515 Doctors Court, Oshkosh 54901
France, Nancy K., 1300 University Ave., Madison 53706
Gerend, Jacob M., 827 Ellen Lane, Fond du Lac 54935
Grotenhuis, Paul W., Route #1, Rhinelander 54501
Hinz, William M., 1551 Dousman St., Green Bay 54303
Kadell, Jerome, 2130 Center Ave., Madison 53704
Karofsky, Peter S., 5601 Odana Rd., Madison 53711
Katz, Jordan, 1300 University Ave., Madison 53706
Kengis, Janis J., 1111 Delafield, Waukesha 53186
Kern. Martin W., 1111 Delafield, Waukesha 53186
Khanna, Trilok S., 2020 E. Milwaukee St., Janesville 53545
Kim, Young Ki, Mt. Calvary Medical Center, Mt. Calvary 53057
Kirkham, Wayne R., 6652 Offshore Dr., Madison 53705
Lamont, Frederick J., 123 North Military Ave., Green Bay 54303
Lamphere, Richard L., 566 North Washington St., Janesville 53545
Lawrence, George H., 845 South Webtser Ave., Green Bay 54301
Leagus, Charles J., Jr., Wausau Hospital North, Wausau 54401
Martalock, Dean L., 815 South 10th St., La Crosse 54601
McCullough, Frank S., 1751 Deckner Ave., Green Bay 54302
Miller, David, 2175 Moccasin Trail, Beloit 53511
Motto, Joseph D., Jr., 733 W. Clairemont Ave., Eau Claire 54701
Pinn, Christopher C., 1821 South Webster Ave., Green Bay 54301
Rhoades, Bruce C., 400 East Thomas St., Wausau 54401
Rosen, Stanley R., 3009 W. 88th Place, Kenosha 53140
Sarhaddi, Shamseddin, 1160 Mt. Mary Drive, Green Bay 54302
Schuster, James E., 333 N. Peters Ave., Fond du Lac 54935
Stanko, Ivan, 400 E. Thomas St., Wausau 54401
Taylor, Neal, 1836 South Ave., La Crosse 54601
Trepanier, Gay D., 525 E. Division St., Fond du Lac 54935
Utz, Philip H., 709 South 10th St., La Crosse 54601
Wargin, Roger C., P. O. Box 1054, Green Bay 54301
Willard, James E., 2211 Stout Rd., Menomonie 54751
Yap, Vincente U., 2500 Overlook Terr., Madison 53705

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Blackman, Helen J., 4162 Kessler Blvd., North Drive, Indianapolis, IN 46208
Bodner, Aaron C., 700 North Water St., Milwaukee 53202
Brennan, John T., P. O. Box 1231, La Crosse 54601
Chandrasekharan, R. G., 5542 West Fond du Lac, Milwaukee 53216
Chatterjee, A. N., 715-2nd Ave., Antigo 54409
Chisholm, Thomas P., 403 Lumpkin, Fort Benning, GA 31905
Clarke, B. Earl, 117 Dearborn, Goleta, CA 93017
Daniells, Albert S., 301 Superior Ave., Tomah 54660
Driessel, Richard H., 5600 Fishers Lane, Rockville, MD 20852
Dudiak, Stephen, 20 South Park St., Madison 53715
Elliott, Richard S., 1224 F Street, Apt. 3, Davis, CA 95616
Erwin, Constance J. R., 1020 Lake Country Court, Oconomowoc 53066
Garrison, Rogers E., 720-4th St., South, Wisconsin Rapids 54494
Gascoigne, C. C., Rural Route, Morenci 49256
Goodman, Jay S., 1218 West Kilbourn, Milwaukee 53233
Hatleberg, C. B., 417 West Willow St., Chippewa Falls 54729
Hillan, Donald D., 1111 Delafield Ave., Waukesha 53186
Hudson, Edward D., 1005 Geneva St., Lake Geneva 53147
Huebner, Jewel S., 3827 Red Oak Court, Oshkosh 54901
Hurley, John D., 610 North 19th St., Milwaukee 53233
Iber, Frank C., Route #1, Box 43, Stevens Point 54481
Jiongco, Eduardo C., 65 Lucille St., Fort Atkinson 53538
Johnson, J. Howard, 10418 Bright Angel Circle, Sun City, AZ 85351
Jolin, James L., 610 North 19th St., Milwaukee 53233
Jovanovic, Dusan, 5520 Medical Circle, Madison 53719
Kingham, James D., 1626 North Prospect, Milwaukee 53202
Kordecki, Frank A., 615 North 8th St., Manitowoc 54220
Lambert, Joseph W., 710 Virginia St., Antigo 54409
Lameka, Peter, 680 Lac La Belle Drive, Oconomowoc 53066
Larson, Arthur N., 800 Bartlett St., Huntington, IN 46750
Martineau, Edward L., 4101 North Ardmore, Milwaukee 53211
Meisekothen, W. E., 5003 Monona Dr., Madison 53716
Meyer, Walter W., 101 North Gibson, Medford 54451
Miller, Charles O., 2709-6th St., Monroe 53566
Minich, William G., P. O. Box 584, Milwaukee 53201
Minnihan, Richard L., 916 Franklin St., Wausau 54401
Morgan, Sherburne F., 130 Madonna Circle, Crowley, TX 76036
Odulio, Teofilo O., Ridgewood Bldg., North 7th St., Wausau 54401
Mohini, Raisinghani, 6901 West Chapman, Milwaukee 53220
Riabov, Sviatoslav N., 2742 North Sherman Blvd., Milwaukee 53210
Scheunemann, W. E., P. O. Box 380, West Bend 53095
Schmidt, Herbert G., 2710 East Newton, Milwaukee 53211
Schmitz, Peter W., 906 Laurie Dr., Madison 53711
Silberman, Richard E., 6361 North Lake Dr., Milwaukee 53217
Soifer, Morton M., 836 North 12th St., Milwaukee 53233
Spelbring, Paul G., 2703 Thomas Street, Apt. 9, Eau Claire 54701
Springer, Donald W., 2709-6th St., Monroe 53566
Swingle, John D., 3700 Queens Ave., La Crosse 54601
Tejero, Jonas S., 4 Bellerine Court, St. Charles, MO 63301
Wagner, Philip C., 3225 Evergreen Rd., Fargo, ND 58102
Walter, William A., 1030 Oakridge Dr., Eau Claire 54701
Watts, Edwin S., 34810 Pabst Rd., Oconomowoc 53006
Westley, William, Jr., 8660 Midland, Greendale 53129
Williams, Gail H., 609 West 14th St., Marshfield 54449
Wojta, William C., 57 Woodland, Fond du Lac 54935

DEATHS

Garbisch, Fred H., Langlade County, June 28, 1973
Rufflo, Anthony F., Kenosha County, Aug. 20, 1973
McCabe, John, Milwaukee County, Sept. 6, 1973
Swarthout, Edyth C., La Crosse County, Sept. 10, 1973
Hyslop, Volney B., Milwaukee County, Sept. 13, 1973
Dorr, Thomas W., nonmember, Sept. 29, 1973
Pember, Aubrey H., Rock County, Sept. 29, 1973
Riordan, John F., Portage County, Sept. 29, 1973 □

the wisconsin medical journal

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Journal Established 1903

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The symbols used to indicate in which department the matter indexed appears are as follows: E—Editorial, PP—President's Page, CT—Comments on Treatment, and GS—Green Sheet. These symbols precede page number. When a double number such as 2-37 appears, the first number refers to the month of issue; the second number to the page. When a single number such as 385 appears, the number refers to the scientific section which is numbered consecutively through the 12 issues of the volume. The following table indicates the page numbers of the scientific section for each month.

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Back Pain Relief Reported by MD

Radio frequency destruction of articular nerves of the facets seems to hold promise in relieving disabling back pain, a LaCrosse, Wis. investigator reports.

C. Norman Shealy, MD, told the 15th annual meeting of the American Assn. for the Study of Headache that "it is much too early to be certain of the long-term results."

However, he said, use of the procedure to date on 60 patients (compression fractures, discogenic pain, etc.) produced "good" results in 24, "excellent" in 30, and failure in six. None had prior surgery for their back problems.

In 30 with previous lumbar surgery, results were "good" in eight, "excellent" in 13, and nine were failures. In 50 patients with lumbar fusion, half were failures, 17 "good," and eight "excellent."

The association held its program this weekend at the Plaza.—*AMA Daily Bulletin* of AMA Annual Meeting, June 25, 1973.

★

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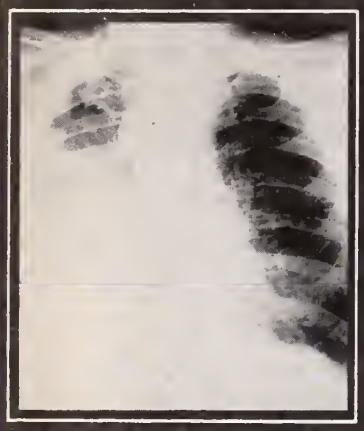
HERE Pleural effusion



Wherever it hurts, Empirin Compound with Codeine usually provides the relief needed.

HERE Biliary calculi

In general, only pain so severe that it requires morphine is beyond the scope of Empirin Compound with Codeine.

Ⓒ III **prescribing convenience:** up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

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WHEREVER IT HURTS

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MEDICAL YELLOW PAGES

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, and MISCELLANEOUS. RATES: 20¢ per word, with a minimum charge of $8.00 per ad. Additional insertions of same ad at 15¢ per word, with minimum charge of $6.00, maximum time one year. BOXED AD RATES: $10.00 per column inch for first insertion, $8.00 per column inch for succeeding insertions of same ad up to one year. DEADLINE: Copy must be received by the first of the month preceding month of issue; e.g., copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

PHYSICIANS EXCHANGE

MEDIHC (MILITARY EXPERIence Directed Into Health Careers) is an employment referral and educational/vocational counseling service for veterans with military training and experience in allied health occupations. A cooperative effort of DOD and HEW on the national level, MEDIHC in Wisconsin is sponsored by the Wisconsin Health Council, Inc., under a contract with the National Institutes of Health. MEDIHC can be of assistance to any employer of allied health personnel in identifying potential employees. For further information and a current listing of medically trained veterans seeking employment and/or further training related to their military backgrounds, contact: Craig A. Piernot, MEDIHC Coordinator, Wisconsin Health Council, Inc., 330 East Lakeside, Box 1109, Madison, Wis. 53701. Tel: 608/257-6781. 12tfn

WANTED: GENERAL PRACTIIoner to practice in new clinic just completed. Excellent opportunity in a resort and recreational county seat community. Ideal financial arrangements can be made. Contact Mayor Ken Bentley, Montello, Wis. 53949. 12tfn

IMMEDIATE OPENING FOR OB-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wis. 54220. 1-12/73

PHYSICIANS NEEDED FOR GENeral practice at Northern Wisconsin Colony and Training School, Chippewa Falls, Wisconsin. Good salary plus civil service benefits. New hospital and infirmary facilities. Contact A. C. Nelson, Superintendent, Box 340, Chippewa Falls, Wis. 54729. Tel. 715/723-5542. An equal opportunity employer. 7-12/73

GENERALISTS OR SPECIALISTS with general knowledge and interests to join booming practice in midwestern Wisconsin. Outstanding facilities. Salary or percentage. An exceptional opportunity. Contact Dept. 395 in care of the Journal. 5tfn/73

OUTSTANDING OPPORTUNITY for one or two OB-GYN physicians to join two certified OB-GYNs in new condominium building in Green Bay, Wis. Two excellent hospitals adjacent to the office building. Opportunity to participate in medical school teaching and do clinical research if desired. Minimum starting salary of $45,000 to the right man. Call or write H. F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

THE RACINE MEDICAL CLINIC, SC, a group of 16 physicians in a diagnostic and family health center multispecialty practice, is seeking primary care physicians with specialties in FAMILY or GENERAL PRACTICE, INTERNAL MEDICINE, and PEDIATRICS. Excellent income and benefits with full ownership at minimum cost within 18 months. Please send curriculum vitae to: R. D. Lacock, Administrator, 5625 Washington Ave., Racine, Wis. 53406. Tel: 414/637-8821. p7tfn/73

FAMILY PRACTITIONER AND/OR internist needed in a busy five-man family practice and multi-specialty group in northeastern Wisconsin. Liberal benefits and salary leading to full association after one year. Located on the shores of Lake Michigan at Two Rivers, Wisconsin. Please contact R. E. Myers, MD, 2219 Garfield St., Two Rivers, Wis. 54241. 4tfn/73

THE MIDELFORT CLINIC IS seeking associates in the following areas:

1. Allergy
2. Family Practice

This is an opportunity to join a 25-man Wisconsin group located in college community of 46,000 with excellent hospital facilities. For further information, contact D. R. Griffith, MD, Midelfort Clinic, Eau Claire, Wis. 10-12/73

EXCELLENT OPPORTUNITY. SURgeon and two Board Certified family practitioners desire a general practitioner to associate. Our practice has reached a point where we need an associate to help take care of patients in a growing community. New bilevel clinic building with dentist and pharmacy located next to a new hospital which is being expanded. Located in Roche-a-Cri Vacationland with many lakes for skiing and fishing, excellent ski hill, country club with golf course. Contact Arthur R. Weihe, MD, or Martin L. Janssen, MD, Roche-a-Cri Clinic, Friendship, Wis. 53934; tel. 608/339-3326. 6tfn/72

THE MONROE CLINIC IS INTERviewing Surgical and Medical Specialists to join the present 39 MD staff. Excellent office facilities and a most modern 360-bed hospital. Top offers in salary and fringe benefits. Monroe is a unique community with tremendous family living conditions with large city opportunities. We have openings in the following Medical and Surgical Specialties:

1. Urology
2. Obstetrics and Gynecology
3. Orthopedic Surgery
4. Otolaryngology
5. Family Practice
6. Gastroenterology
7. Cardiology
8. General Internal Medicine

Please contact Robert E. Hassler, MD, Procurement Chairman, The Monroe Clinic, Monroe, Wis. Tel: 608/325-7121. 9tfn/73

PROGRESSIVE, MULTISPECIALTY 8-physician group needs 2 OB-GYN specialists. Many corporate benefits include corporate membership, profit sharing, health, disability and liability insurance. Dynamic community of 18,000 ideally located in scenic area 30 miles northwest of Milwaukee. Excellent recreational, educational, civic and hospital facilities. Inquire General Clinic of West Bend Inc., P.O. Box 178, West Bend, Wis. 53095. 11tfn/72

KROHN CLINIC, LTD., NEEDS physician interested in rural family practice. Group of six presently includes five ABFP plus board surgeon. Excellent situation for young physician, preferably not over 32, and desiring interesting variety in practice. New clinic building and new 70-bed hospital. Contact Wm. B. Wilcox, Mgr., Krohn Clinic, Ltd., 610 West Adams St., Black River Falls, Wis. 54615, or call collect 715/284-4311. 10tfn/73

INTERNIST OR FAMILY PHYSIcian to practice in established clinic. Attractive city of 4000, plus surrounding area. Near Madison. 75-bed hospital with plans for expansion. Contact Dept. 399 in care of the Journal. 10-12/73, 1-3/74

GENERAL PRACTITIONER wanted: Multi-specialty group practice in Milwaukee suburb. New clinic building. Excellent hospital nearby. Fine salary and benefit program. Contact: Mr. R. R. Grigg, 3533 East Ramsey Ave., Cudahy, Wis. 53110. 10-12/73

FAMILY PRACTICE OPENING January, 1974 in two-man office. Cashmere, Wash., outstanding orchard community. Scenic area with unlimited recreational opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, MD (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Wash. 98815. Tel: 509/782-1541. 9/73-8/74

ENJOY THE BEST OF TWO worlds! Discover Watertown, Wisconsin. No traffic congestion, smog, crime or other big city unpleasantness. Peaceful environment with new 100-bed general hospital and new connecting (but separate) medical office building. Good location to Madison and Milwaukee medical centers. Medical practice area includes over 40,000 people. Progressive community. New schools. Many parks, trees and recreational facilities. Stable economy. If you are a family practitioner, an internist, an orthopedist, and interested in a new solo or group private practice, write or call: Leo B. Bargielski, Executive Director, Watertown Memorial Hospital, Watertown, Wis. 53094. Tel: 414/261-4210. 10-12/73

EXCELLENT OPPORTUNITY: GP or FP for busy established incorporated practice in thriving community of 6800. Superior educational and recreational facilities. Modern well-equipped clinic adjacent 85-bed hospital. Starting salary open, partnership after one year. Phone, visit, or write: C. E. Kozarek, MD, 325 Butts Ave., Tomah, Wis. 54660. Tel: 608/372-4177. 10tfn/73

WANTED: GENERAL PRACTITIONER in city of Markesan, Green Lake County, Wis., to join two AAFP members, so that we can all enjoy more normal time for relaxation and family life. Salary first year, partnership thereafter. Contact D. P. Cupery, MD, Markesan Medical Center, P.O. Box 247, Markesan, Wis. 53946. 8-12/73

THE WAUSAU MEDICAL CENTER (formerly Wausau Clinic), a family medicine-multispecialty group of 42 physicians, is seeking the association of physicians in the following areas of practice:

1. General Surgery
2. Orthopedic Surgery
3. Otolaryngology
4. Anesthesiology
5. Internal Medicine
6. Physiatry
7. Family Medicine

First year salary open. Full membership in two years. Fringe benefits include retirement plan, medical and hospial insurance, life insurance. Excellent vacation and time-off plan. Metropolitan area of 50,000 adjacent to the finest vacation area in the Midwest. Excellent general hospital of 375 beds. For further information write W. T. Becker, MD, Medical Director, Wausau Medical Center, 400 E. Thomas St., Wausau, Wis. 54401; or call collect: 715/842-0411. 10-12tfn/73

WANTED: GP TO JOIN 3-MAN group, Wild Rose Clinic, Ltd. in Central Wisconsin vacationland. Clinic located next to new, modern hospital. Salary negotiable. Call 414/622-3329. 11tfn/73

INTERNIST—PEDIATRICIAN: 15-man multi-specialty group; SE Wisconsin five-man Internal Medicine needs more help. Located ideally between Chicago and Milwaukee on Lake Michigan's shoreline. Excellent salary, partnership possible after one year, no capital investment. Contact Stan Englander, MD, Kurten Medical Group, 2405 Northwestern Ave., Racine, Wis. Tel.: 414/637-9271. 4tfn/72

WISCONSIN MULTI-SPECIALTY group of 17 physicians has openings in the following specialties: Internal Medicine, presently six men, general or subspecialty training; Otolaryngology, presently one-man department; Allergy, an excellent opportunity as this specialty is not covered in our community. Attractive starting salary, no investment, corporate organization, exceptional pension and insurance programs, progressive community of 45,000. Include curriculum vitae with correspondence. For further information please contact Francis R. Russo, MD, Janesville Riverview Clinic Ltd., Box 551, Janesville, Wis. 53545. 9tfn/73

INTERNIST AND PEDIATRICIAN wanted: Incorporated group of three general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Anyone interested write to Dr. I. E. Schiek, Jr. or Dr. Otto G. Rosemeyer, c/o The Schiek Clinic, S.C., Rhinelander, Wis. 54501, or call collect 715/362-6160. 11-12/73, 1-10/74

THE MARSHFIELD CLINIC IS seeking additional specialists in many areas. This opportunity combines a busy, stimulating referral practice plus an active local practice with an opportunity for family medicine. We provide excellent salary and fringe benefits as well as opportunities for research and teaching. Excellent retirement program and insurance plan. Modern 7-story office building with all diagnostic facilities available. Excellent 400-bed hospital. We are looking for physicians in the following specialties:

1. Pediatrics—General—Hematology
2. General Surgery
3. Orthopedic Surgery
4. Plastic Surgery

For further information, please contact Russell F. Lewis, MD, Medical Director, Marshfield Clinic, Marshfield, Wis. 54449. 11-12/73, 1-2/74

THE MEDFORD CLINIC HAS IMmediate openings in OB-GYN and general practice. Excellent adjacent 110-bed hospital. Beginning salary $30,000. Retirement and other group benefits. Participation in corporation available but not required. Contact: Walther W. Meyer, MD, 101 N. Gibson Ave., Medford, Wis. 54451. Tel: 715/748-2121. 11-12/73, 1-4/74

SECOND GENERAL PRACTITIONER needed by eleven man multi-specialty clinic. One aspect of this position is to also share in the practice of industrial medicine. Limited night call, if any. Salary negotiable, many fringe benefits. Associate status possible after one full calendar year. Contact: Administrator, Medical-Surgical Clinic, S.C., 2500 West Lincoln Ave., Milwaukee, Wis. 53215 11-12/73, 1-4/74

GENERAL PRACTITIONER AND psychiatrist openings. Expanding program in 430-bed university-affiliated hospital. Attractive hours, liberal fringe benefits, excellent retirement plan. Starting salary in the $28,000 to $34,000 range. Contact Chief of Staff, VA Hospital, Madison, WI 53705. Phone 608/256-1901, ext. 311. Nondiscrimination employer. 11-12/73, 1/74

FAMILY PRACTITIONER, INTERNist, Pediatrician, Orthopedist, OB-GYN —Board Certified or Board Eligible—wanted by expanding multispecialty group in Madison, Wis. City has university, excellent hospitals, schools, and recreational facilities. Immediate openings. Salary competitive. Write: Mr. Robert W. Graff, Bus. Mgr., 2 W. Gorham St., Madison, Wis. 53703. p11-12/73, p1-2/74

PEDIATRICIAN, BOARD ELIGIble, certified, to join three pediatricians with own building, lab, and x-ray, in well established Milwaukee suburban practice. Childrens hospital 15 minutes away. Send curriculum vitae. K. J. Winters, MD, 949 Glenview Ave., Wauwatosa, Wis. 53213. 11-12*/73

IMPORTANT NOTICE: IF YOU are one of the hundreds of parachuting enthusiasts who bought our course entitled Easy Sky Diving in One Fell Swoop, please make the following correction: On page 8, line 7, change "state zip code" to "pull rip cord."—EDITOR NORMAN COUSINS in World Magazine 11/73

FAMILY PRACTITIONERS WANTed to organize and operate Family Practice Department in a 95-man multispecialty group with adjacent 490-bed hospital. Recently completed new clinic building. Gundersen Clinic, Ltd. is in a progressive community with expanding university and private college. Population 51,000. Cultural and recreational facilities. Beautiful setting; good schools. Excellent pension program, no investment required. Service corporation organization. Write: Dr. Robert B. Rasmus, Chairman, Personnel Committee, Gundersen Clinic Ltd., 1836 South Ave, La Crosse, Wis. 54601. 12/73, 1-2/74

WANTED: ORTHOPEDIC SURgeon to associate with multispecialty group in thriving industrial and trade area of 35,000. Complete facilities including x-ray and laboratory in 7-year-old clinic with adjacent 80-bed hospital. Contact Wm. C. P. Hoffmann, MD or Business Manager, 1113 East Sumner St., Hartford, Wis. 53027. Tel: 414/673-5050. p12/73, 1/74

FAMILY PRACTITIONER WANTed for progressive family practice group of five in fast growing city near Milwaukee, Wisconsin. New facilities five minutes from 450-bed hospital. Guaranteed hospital privileges for competent person. Starting salary competitive and negotiable. Subsidized housing available for first year. Contact: Waukesha Medical Clinic, SC, 237 Wisconsin Ave., Waukesha, Wis. 53186, or call collect: J. L. Nolan, MD, tel: 515/542-8150. 12/73, 1-2/74

WANTED: AN INTERNIST AND family practitioner to join a multi-solo group of family physicians; one board general surgeon, one board orthopedic surgeon, and four family physicians in Oconto Falls. Each physician is in solo practice but all cover for each other. Oconto Falls is a friendly progressive community of 2600 people located in northeastern Wisconsin close to Green Bay and offers advantages of rural living with metropolitan availability. The community offers churches, both parochial and public schools, business and almost unlimited recreational opportunities. Our two-year-old hospital is a modern new facility of 104 beds with medical-surgical-obstetrical facilities including 4 intensive care beds and serves an area of approximately 18,000 people. An internist interested in the welfare of his fellow men will have a large referral base. A similar type family physician will shortly have as many patients to care for as he wishes. Space is available for several more physicians in a medical office building adjacent to the hospital. If interested write or call Clyde E. Siefert, MD, 105 William St., Oconto Falls, Wis. 54154. Home tel. 414/846-2253. Office tel. 414/846-3671. 12/73-1/74*

MEDICAL FACILITIES

EXCELLENT OPPORTUNITY FOR pediatricians and internists to establish practice in beautiful new physicians condominium building adjacent to Bellin and St. Vincent hospitals in Green Bay, Wis. Patients immediately available on referral from other physicians in the building. Call or write H.F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 S. Webster Ave., Green Bay, Wis. 54301. 7tfn/73

TWO MORE DOCTORS NEEDED in Ripon. Modern four-year-old medical clinic building available for rent or sale, specifically built for two or three doctors. Contact: Mrs. O. A. Dittmer, 612 Woodside Ave., Ripon, Wis. 54971; tel. 414/748-3636. g4tfn/73

NOW LEASING FOR LATE 1974 occupancy, a new medical building connected to a 275-bed hospital in the rapidly growing northeast suburb of Minneapolis. Suites will be custom designed to suit individual tenants. For further information, contact J. L. Harty, MD, c/o Unity Hospital, 550 Osborne Road, Fridley, MN 55432. Phone: 612/786-2200. 11-12/73

WANTED: PHYSICIAN FOR small farming community 20 miles from Chippewa Falls. Hospital 5 miles. Serving 3500 pop. Office space available in new medical building. Contact Mr. Jno. W. Meyer, State Bank of Boyd, Boyd, Wis. 11tfn/72

MISCELLANEOUS

GUIDELINES FOR BLOOD—ALCOhol testing by physicians, available from the CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. Includes request/consent form for drawing blood. Cost: 25¢ per form to be sent with order.

FOR SALE: CHARMING CIVIL war era brick colonial house, set among ancient oak trees near Madison. Four bedrooms, 2½ baths, slate entry, double fireplace, indoor barbecue, 20x38 swimming pool. Acreage and other buildings if desired. Bus pickup at front door to accredited schools. Contact Dept. 402 in care of the Journal. g12/73

ANNOUNCEMENTS

STROKE AND KIDNEY Classification Studies have been released for comment by the Joint Commission on Accreditation of Hospitals (JCAH). The studies, which were contracted by the Department of HEW, were undertaken by the Joint Commission's Listing Program for Specialized Clinical Services. Dr. John D. Porterfield, Director of the JCAH, says that "the reason JCAH is publicizing the availability of these studies is so that professionals who perform in these areas of concern will take this opportunity to review the data. This will permit their opinions and comments to be considered now, prior to final approval and adoption of the criteria by JCAH. In other words," he says, "this is the physician's chance for direct and personal input into the decision-making process of accepting these very important medically related criteria."

Study one, "Optimal Criteria for End-stage Kidney Disease Care," classifies the entities of care by procedure:

1) kidney transplantation and dialysis, and
2) dialysis only.

Study two, "Optimal Criteria for the Care of Patients with Stroke," classifies the entities of care by descriptive category:

1) regional stroke centers of care,
2) comprehensive specialized services,
3) selected advanced specialized services, and
4) basic limited specialized services.

Copies of the kidney and stroke studies are available at no charge from John D. Porterfield, MD, Director, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave., Chicago, IL 60611.

ANY COMMUNITY NEEDING AN otolaryngologist is invited to contact the American Council of Otolaryngology for help. The Council does not promise to produce an immediate prospect, but it does pledge that it will call the community's need to the attention of senior residents in otolaryngology who are known to be looking for practice opportunities.

Doctors in private practice, medical groups and all individuals commissioned by their medical communities to search for an otolaryngologist should briefly outline the position available when writing the Council.

There are two ways in which the Council can advise otolaryngologists of the community need, Raymond E. Jordan, M.D., executive Director, explained:

1. It can notify those senior otolaryngology residents who have specifically advised the Council that they are looking for a position.
2. It can further communicate the community's need through a newsletter reaching all practicing otolaryngologists in the United States and Canada.

Letters should be addressed to: The American Council of Otolaryngology, Suite 602 — 1100 17th St., N.W., Washington, D. C. 20036.

PUBLICATIONS

A Doctor Discusses Allergy: Facts and Fiction. By Lou Joseph, BA in consultation with Alice S. Mills, MD, member, American Academy of Allergy, associate, Department of Medicine, Northwestern University. Published by Budlong Press Company, Chicago. Manual available to the public only through professional sources. Physicians interested in having copies available to their patients should contact: Mr. Larry R. Derzon, Milex Central, 1873 Grove St., Glenview, Ill. 60025; tel. 312/729-5353. 10/73

FILMS

List of medical movies available from the American College of Radiology that all physicians may find useful in continuing education, self-evaluation programs, peer review studies, resident and intern training, etc. can be obtained by writing Charles Honaker, Director of Public Relations, ACR, 20 North Wacker Drive, Chicago, Ill. 60606; tel. 312/236-4963. 10/73

The Accident Bug is a 25-minute, 16mm color film on OSH Act (Occupational Safety and Health Act) reporting forms, creating a crash course in this vital piece of legislation for every employer engaged in commerce and industy. It is available for rental or sale from Association-Sterling Films, 866 Third Avenue, New York, New York 10011.

Ideally suited for the busy executive who may require only a basic outline of what the Act entails, or as a short visual course for such key staff members as personnel directors, safety engineers, superintendents and medical departments.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1973 through Aug. 31, 1974 appeared in JAMA (Supplement) Aug. 13, 1973.*

1974 WISCONSIN

Jan. 9: In-depth Teaching Program, State Medical Society of Wisconsin, Madison General Hospital, Madison.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

University of Wisconsin
Center for Health Sciences and UW-Extension/Madison
1973-1974

ON-CAMPUS CONFERENCES In Continuing Medical Education

Nov. 29-30: *Quality of Care Conference*

Jan. 25-26: *Exercise—As Therapeutic Tool*

Mar. 28-30: *How to Teach Family Medicine*

Apr. 24-26: *Sports Education*

May 9-11: *Emergency Medical Care of Critically Injured*

Aug. 12-16: *Emergency Medical Care*

Nov. 1-2: *Pediatric Surgery*

Nov. 7-9: *Acupuncture*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

Jan 9: In-depth teaching program—"Critical Criteria in the Hospital Management of Obstetrics," sponsored by State Medical Society of Wisconsin in cooperation with University of Wisconsin Medical School Faculty, St. Marys Hospital Medical Center, Madison General Hospital, Madison Chapter—Wisconsin Academy of Family Physicians, and Postgraduate Program —Merck, Sharp & Dohme. At Madison General Hospital, Madison.

Jan 14-18: Kidney Disease, Fluid and Electrolyte Metabolism, five-day course at Milwaukee County General Hospital, Milwaukee. Offered by the Kidney Foundation of Wisconsin in cooperation with the Office of Continuing Education of the Medical College of Wisconsin and the Renal Unit, Division of Medicine, MCW; and Milwaukee County General Hospital. Accreditation: 35 hours of prescribed credit by the American Academy of Family Physicians. Fee: $100. Limited enrollment: 30.

Jan. 15: 88th Annual Dinner Meeting, Milwaukee Academy of Medicine, University Club of Milwaukee, Milwaukee. Speaker: Dr Louis C Lasagna, Professor and Chairman, Department of Pharmacology and Toxicology, University of Rochester School of Medicine and Dentistry; subject: "Informed Consent."

Jan 24-27: Fourth Annual Winter Refresher Course for Family Physicians, Medical College of Wisconsin, at the Pfister Hotel and Tower in Milwaukee. Cosponsored by the Wisconsin Academy of Family Physicians. Info: Continuing Education Dept, MCW, 561 N 15th St, Milwaukee, WI 53233. Tel 414/272-5450, ext 320.

Feb. 1-2: Cardiology Symposium, St Marys Hospital Medical Center, Madison. Info: Inservice Program Director, St Marys HMC, 720 South Brooks, Madison, WI 53715. Tel: 608/251-6100.

Feb. 2-3: Council Meeting, State Medical Society of Wisconsin, Madison.

Feb. 12-14: Wisconsin Academy of Family Physicians Winter Conference, Mt. Telemark, Cable.

Feb. 21: Family Practice Off-Campus Conference on Allergies and Lab Test, North Hospital, Wausau.

Feb 23-24: "Emergency Care," offered by Medical College of Wisconsin's Dept of Surgery, at Pfister Hotel, Milwaukee. Info: Anne T Finnegan, Conference Coordinator, MCW, 561 N 15th St, Milwaukee, WI 53233. Tel 414/272-5450, ext 247.

Feb. 28: In-depth Teaching Program, State Medical Society of Wisconsin, St. Marys Hospital Medical Center, Madison.

Mar. 25-26: Annual Scientific Program. State Medical Society of Wisconsin, Milwaukee.

Mar. 26: Spring meeting, Wisconsin Surgical Society, in conjunction with the Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee.

Apr. 10: Family Practice Off-Campus Conference on Allergies and Lab Test, Sacred Heart Hospital, Eau Claire.

Apr 10-11: Medical Audit Team Seminars (MATS), jointly sponsored by the Wisconsin Hospital Association and the State Medical Society of Wisconsin in cooperation with the Joint Commission on Accreditation of Hospitals. Location pending.

Apr. 17-19: Second annual course for nurses involved in emergency care: "Emergency '74," sponsored by the Wisconsin Committee on Trauma of the American College of Surgeons, at Pfister Hotel and Tower in Milwaukee. Info: Joseph C. Darin, MD, 8700 West Wisconsin Ave., Milwaukee, WI 53226.

Apr. 18: Family Practice Off-Campus Conference on Peptic Ulcer and Breast Cancer, North Hospital, Wausau.

May 8: Family Practice Off-Campus Conference on Peptic Ulcer and Breast Cancer, Sacred Heart Hospital, Eau Claire.

June 21-23: Wisconsin Academy of Family Physicians Annual Meeting, Abbey, Fontana.

Sept. 11-14: Wisconsin Society of Internal Medicine meeting at Telemark Lodge, Cable.

Sept. 13-14: Fall meeting, Wisconsin Surgical Society, Dellview Hotel, Lake Delton.

1974 NEIGHBORING

Jan 25-26: Illinois Regional Meeting, American College of Physicians, Ramada Convention Center, Ramada Inn, Urbana, Ill. Info: Richard Allyn, MD, 107 South 5th St., Springfield, Ill. 62701.

Feb. 12-15: Annual four-day "Refresher Course for the Family Physician," University of Iowa Memorial Union, Iowa City. Info: Director, Office of Continuing Medical Education. The University of Iowa, Iowa City, IA 52242.

Mar. 18-21: Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

Mar. 18-23: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital. Info: Dept. of O, Eye and Ear Infirmary, 1855 West Taylor St., Chicago, Ill. 60612.

☐ Copy deadline for MEDICAL MEETINGS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, Wisconsin 53701.

Mar. 31-Apr. 6: American Rhinologic Society and Illinois Masonic Medical Center will present introductory course in (A) Functional Corrective Surgery of the Nasal Septum and the External Nasal Pyramid, (B) Rhinomanometry and Naso-Antral Manometry, and (C) Basic Principles of Respiratory Physiology and Fundamental Diagnostic Tests—Pulmonary, Cardiac, Blood Gas Analysis, Nasal Function Tests, and Introducing Naso-Pulmonary Function Tests, in Chicago, Ill. Course approved by AMA Council on Medical Education. Info: Pat A. Barelli, MD, Secretary, ARS, 4177 Broadway, Kansas City, MO 74111.

Apr. 15-19: Clinical Endocrinology: Recent Advances in Diagnosis and Treatment, American College of Physicians, Mayo Clinic, Rochester, Minn.

May 19-31: Cardiac Auscultation, American College of Physicians, Mayo Clinic, Rochester, Minn.

May 29-Jun 1: Ninth annual Conference of the Association for the Care of Children in Hospitals, Sheraton-Chicago Hotel, Chicago. Info: Mrs Myrtha Sicé, Publicity Chairman, ACCH '74 Conference, Children's Memorial Hospital, 2300 Children's Plaza, Chicago, IL 60614.

Jun 1-5: Multidisciplinary Workshop in Facial Plastic Surgery, Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois (in cooperation with the American Academy of Facial Plastic and Reconstructive Surgery, Inc.). Info: Dept of O, Eye and Ear Infirmary, 1855 West Taylor St., Chicago, Ill. 60612.

June 10-12: New Diagnostic and Therapeutic Modalities in Internal Medicine, American College of Physicians, University of Iowa, Iowa City, Ia.

Oct. 6–10: Annual Meeting, Michigan State Medical Society, Detroit.

1974 OTHERS

Jan. 16-17: Gastrointestinal Surgery, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, OH 44106.

Jan. 22-24: 3rd Annual Pediatric Pulmonary Course, Louisiana State University Medical Center, New Orleans, La. Info: W. Findley Raymond, Exec. Dir., A.L.A. of La., Inc., 333 St. Charles Ave., Suite 1504, New Orleans, La. 70130.

Jan. 26-Feb. 9: 15th Postgraduate Medical Seminar Cruise, Dept. of Postgraduate Medicine of Albany Medical College. Info: Frank M. Woolsey Jr., MD, Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

Jan 30-Feb 1: Postgraduate course, "Practical Clinical Pulmonary Physiology," Sponsors: American College of Chest Physicians, Northern Ohio Lung Association, Case Western Reserve University School of Medicine, Ohio Lung Association, and the American Thoracic Society. At Case Western Reserve U School of Medicine—Auditorium, Cleveland, Ohio. Registration fees: ACCP, ATS members, $100; nonmembers, $125; residents, $50. Registration info: Bradford W Claxton, MEd, Director of Continuing Education, ACCP, 112 East Chestnut St, Chicago, IL 60611.

Feb. 12-15: Annual Meeting of the American Academy of Forensic Sciences, Statler-Hilton, Dallas, Tex. Info: AAFS, 11400 Rockville Pike, Rockville, MD 20852.

Mar 14-15: Annual Postgraduate Course in Pediatrics of the University of Texas Medical Branch, "Pediatric Potpourri," in Galveston, Tex. Info: Lillian H Lockhart, MD, Chrmn, Pediatric Postgraduate Committee, U of Texas Medical Branch, Galveston, TX 77550.

Mar 25-28: Second annual four-day spring meeting, American College of Surgeons, at the Albert Thomas Convention Center and Hyatt Regency Hotel, Houston, Tex. Info: ACS, 55 East Erie St, Chicago, IL 60611.

Apr 28-May 2: American Industrial Health Conference, Americana Hotel, Bal Harbour, Fla. Info: 150 North Wacker Drive, Chicago, Ill. 60606.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings 1974—1978

Mar 23-26, 1974: Pfister Hotel, Milwaukee
Apr 5-8, 1975: Pfister Hotel, Milwaukee
Mar 27-30, 1976: The Madison Hilton, Madison
Mar 26-29, 1977: Pfister Hotel, Milwaukee
Apr 1-4, 1978: Pfister Hotel, Milwaukee
Further information:
David C. Reynolds, Director
Scientific Affairs
State Medical Society of Wisconsin
Box 1109, Madison, WI 53701

Family Practice Off-Campus Conferences

EAU CLAIRE GREEN BAY WAUSAU

Presented by: University of Wisconsin Center for Health Sciences; Department of Continuing Medical Education, Health Sciences Unit, UW-Extension; CES Foundation, State Medical Society of Wisconsin; and Wisconsin Academy of Family Physicians

Dates	*Topics*	*Madison Faculty*	*Eau Claire Faculty*	*Wausau Faculty*
Feb. 21	ALLERGIES	Charles Reed, MD		Norman Deffner, MD David Aughenbaugh, MD
Feb. 21	LAB TEST	Dean Connors, MD		Richard Bartholomew, MD
Apr. 10	ALLERGIES	Charles Reed, MD	Bright Larkin, MD Mrs. M. Johnson	
Apr. 10	LAB TEST	Dean Connors, MD	Robert Fink, MD	
Apr. 18	PEPTIC ULCER	Robert Barreras, MD		Bruce Gargas, MD
Apr. 18	BREAST CANCER	Hugh Davis, MD		Erling Ravn, Jr., MD
May 8	PEPTIC ULCER	Robert Barreras, MD	Joseph Motto, MD	
May 8	BREAST CANCER	Hugh Davis, MD	Ralph Hudson, MD	

Locations

Eau Claire Sacred Heart Hospital/Coordinator: Lou Raymond, MD
Wausau North Hospital/Coordinator: Curt G. Grauer, MD
(Green Bay Conferences: Spring 1974)

16 Hours WAFP Credit Applied For — Individual Sessions: $10

Registration: 9:30 A. M. — Adjournment: 3:30 P.M.

Registration to: Wisconsin Center, 702 Langdon St., Madison, Wis. 53706. Include check for $10 (each session) payable to UW-Extension, name, address, city, zip code, social security number, and phone number.

For more information, contact: Bill Wendle, Department of Continuing Medical Education, Room 560, WARF Building, 610 Walnut Street, Madison, Wis. 53706; tel. 608/263-2855.

May 3-17: 26th Annual Congress and Academy of Proctology, Montreux and Zurich, Switzerland. Info: Executive Offices, 147-41 Sanford Ave., Att: Alfred J. Cantor, MD, Exec. Sec., Flushing, N.Y. 11355.

July 7-12: XII International Congress on Diseases of the Chest, sponsored by International Academy of Chest Physicians and Surgeons, affiliated with American College of Chest Physicians, in London, England at Royal Festival Hall. Info: American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

Oct. 8-13: Workshops in Hypnosis, in conjunction with 26th Annual Scientific Meeting of Society for Clinical and Experimental Hypnosis, in Montreal, Canada, at Ritz-Carlton Hotel. Info: Germain Lavoie, PhD, Workshops Chairman—SCEH 1974, Hospital Saint-Jean-de-Dieu, Montreal-Gamelin, Quebec, Canada.

THE MEDICAL COLLEGE OF WISCONSIN

Postgraduate Education Programs
Winter/Spring 1974

The Division of Surgery of The Medical College of Wisconsin, through the Office of Continuing Education and with the aid of Eberbach Foundation is sponsoring a series of five Postgraduate Education Conferences during Winter/Spring 1974.

**Jan. 24-27:* "Winter Refresher Course," David Rosenzweig, MD, Course Director, Pfister Hotel, Milwaukee (24 credit hours AAFP).

*Not underwritten by the Eberbach Foundation.

1. *Jan. 25, 26, 1974:* "Colon Disease and Colonscopy," Joseph E. Geenen, MD, Course Director, Pfister Hotel, Milwaukee (10 credit hours AAFP).
2. *Feb. 23, 24, 1974:* "Emergency Care," Joseph Darin, MD, Course Director, Pfister Hotel, Milwaukee (credit hours to be determined).
3. *Apr. 20, 21, 1974:* "Vascular Surgery for the Practicing Physician," Victor M. Bernhard, MD, Course Director, Pfister Hotel, Milwaukee (credit hours to be determined).
4. *May 10, 11, 1974:* "Clinical Immunobiology for the Practicing Physician," Glenn Rodey, MD, Peter Abramoff, PhD, Course Directors, Pfister Hotel, Milwaukee (credit hours to be determined).
5. *May 25, 26, 1974:* "Upper Midwest Review of Gastroenterology," Robert Condon, MD, Course Director, Pfister Hotel, Milwaukee (credit hours to be determined).

Above dates and locations are tentative and are provided for information and planning.

OFFICE OF CONTINUING EDUCATION
Medical College of Wisconsin
561 North 15th Street
Milwaukee, Wisconsin 53233

1975 WISCONSIN

Apr. 5-8: Annual Meeting, State Medical Society of Wisconsin, Marc Plaza Hotel, Milwaukee.

* * *

Colon Disease and Colonoscopy. Postgraduate education course, designed to improve the diagnosis and treatment of the colon including polyps, cancer and inflammatory bowel disease, offered by The Medical College of Wisconsin departments of gastroenterology and surgery through the office of continuing education.

One-and-a-half day course scheduled for January 25 and 26 at Milwaukee's Pfister Hotel.

Course approved for ten hours of prescribed credit by the American Academy of Family Physicians.

Topics include: Instrumentation and Techniques of Colonoscopy; Carbon Dioxide Insufflation During Colonscopic Electrosurgical Polypectomy; Carcinoembryonic Antigens and Cancer of the Colon; Polyps of Colon: X-ray vs. Colonscopy; Inflammatory Bowel Disease; and Electrosurgery and Cancer of the Rectum.

Course is directed by Joseph E. Geenen, MD, associate clinical professor of gastroenterology at the Medical College. Guest faculty participating are: Christopher B. Williams, BM, MRCP, St. Mark's Hospital, London, England; John F. Morrissey, MD, professor of medicine, University of Wisconsin Medical School; B. F. Overholt, MD, professor of medicine, University of Tennessee Medical School, and BH Gerald Rogers, MD, on the staff of Grant and Henrotin Hospitals and a consultant to other hospitals in the Chicago area.

Further info: Dr. Geenen, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226 (Tel. 414-258-2040, Ext. 3133); or Anne T. Finnegan, Conference Planner, The Medical College of Wisconsin (414-272-5450 Ext. 247).

Critical Criteria in the Hospital Management of Obstetrics. An in-depth teaching program of the State Medical Society of Wisconsin presented under auspices of its CES Foundation, Jan 9, 1974, at Madison General Hospital in Madison.

Registration at 9 a.m. Workshops at 10 a.m. Luncheon at 1 p.m. Lecture and discussion at 1:30 p.m. and 2:15 p.m. with adjournment at 3 p.m.

Topics: Premature Rupture of Membranes; Premature Labor, by Jack M. Schneider, MD, associate professor of Gynecology & Obstetrics; Intrauterine Fetal Death (20 weeks or more), by Luis B. Curet, MD, associate professor of Gynecology & Obstetrics.

Workshops and lectures provided by the University of Wisconsin Medical School Faculty, St. Marys Hospital Medical Center, and Madison General Hospital. Cosponsors: Madison Chapter—Wisconsin Academy of Family Physicians and Postgraduate Program—Merck, Sharp & Dohme.

Further info: David C Reynolds, Director of Scientific Affairs, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701.

Critical Criteria in the Hospital Management of Pediatrics. An in-depth teaching program of the State Medical Society of Wisconsin under auspices of its CES Foundation, Feb. 28, 1974, at St Marys Hospital Medical Center in Madison.

Program schedule same as listed above in the Obstetrics In-Depth Program, same providers and sponsors.

Topics: Childhood Diabetes, by Gerald J Bargman, MD, assistant professor of Pediatrics; and Convulsive Disorders, by Raymond W M Chun, MD, professor of Neurology.

Further info from Mr Reynolds as noted in above item.

Annual Refresher Course For Family Physician. The Medical College of Wisconsin will hold the fourth annual Winter Refresher Course for Family Physicians January 24-27 at the Pfister Hotel and

SCOLIOSIS WORKSHOPS

will be held throughout the state for nurses and other interested groups by the State Division for Handicapped Children on the following dates:

Jan. 14: Madison, 2-4 pm
Jan. 15: Milwaukee, 9-11 am (St. Joseph's Hospital, Room 100)
Jan. 15: Kenosha, 2-4 pm (City Building, Council Chambers)
Jan. 16: Appleton, 9-11 am
Jan. 17: Green Bay, 9-11 am
Jan. 21: La Crosse, 2-4 pm
Jan. 22: Eau Claire, 9-11 am
Jan. 23: Rhinelander, 9-11 am
Jan. 23: Stevens Point, 2-4 pm

The agenda for the workshops, which are identical, consists of an explanation of the screening process, viewing of slides, and how to make referrals. Presentations by Dr. Horace K. Tenney, III. The last hour has been reserved for questions from the floor.

Physicians interested in one of these workshops should contact either their Public Health Nurse or call 608/266-3886.

Tower in Milwaukee. Four-day course co-sponsored by the Wisconsin Academy of Family Physicians. Gayle Stephens, MD, Diplomat, American Board of Family Physicians, and dean. School of Primary Medical Care, The University of Alabama, will be the guest speaker.

According to David Rosenzweig, MD, associate professor of medicine and course director, the course will include review and discussion of medical topics of particular interest to family physicians by faculty specialists and a practice exam for doctors intending to take the family board examination.

Evening sessions will repeat the popular "Meet the Professor" format with cases presented by fellows and residents for discussion.

Course is approved for 24 hours of prescribed credit by the American Academy of Family Physicians.

Registration closes on December 25. Further information can be had from the course director, telephone: 414/257-6355, or the continuing education department of the Medical College of Wisconsin, 561 N 15th Street, Milwaukee, WI 53233; telephone 414/272-5450, Ext. 320.

Emergency Care, a one and-a-half day postgraduate course is being offered by the Medical College of Wisconsin's department of surgery on February 23-24, 1974 at Milwaukee's Pfister Hotel.

Joseph C. Darin, MD, MCW professor of surgery and course director, described the course as emphasizing diagnosis and management of the critically ill patient. "Practical aspects as well as new techniques will be stressed," he said. Larry Carey, MD, professor of surgery, The University of Pittsburgh School of Medicine, will be the guest speaker.

Topics will include acute medical emergencies, initial resuscitation of the shock patient, practical aspects of fluid therapy for shock victims, management of cardio-pulmonary arrest, drug intoxication and overdose and acute vascular and neurosurgical emergencies among others.

Course is approved for ten hours of prescribed credit by the American Academy of Family Physicians. Further info: Course Director at 8700 W. Wisconsin Avenue, Milwaukee, WI 53226, (414) 257-5525, or Anne T. Finnegan, Conference Coordinator, The Medical College of Wisconsin, (414) 272-5450 Ext. 247.

Pediatric Potpourri. Annual postgraduate course of The University of Texas Medical Branch to be held in Galveston, Texas, March 14 and 15, 1974. Guest lecturers: Paul Wehrle, MD, Elliott Ellis, MD, and Marvin Cornblath, MD, Program is acceptable for 12 prescribed hours by the American Academy of Family Physicians and registration fee is $75. Further info: Lillian H Lockhart, MD, chairman, Pediatric Postgraduate Committee, The U of Texas Medical Branch, Galveston, TX 77550.

American College of Surgeons. Second annual four-day spring meeting in Houston, Tex, March 24 through 28, 1974, at the Albert Thomas Convention Center and the Hyatt Regency Hotel. Provides eight postgraduate courses: fluids and electrolytes, cardiovascular surgery, cancer, plastic surgery, shock, gastrointestinal surgery, surgery of the hand, and urologic surgery. Fees approved by the AMA for credit as continuing education courses, $40 for all registrants, manual included. Housing and registration forms available from ACS, 55 East Erie St, Chicago, IL 60611.

Refresher Course for the Family Physician will be held at The University of Iowa Memorial Union Tuesday through Friday, February 12-15. Twenty-three lectures, 60 small-group discussions and case presentations, four panels, and clinical films during the course will consider a broad range of family medical problems.

Among lecture topics will be "How to Recruit Doctors to Smaller Communities —A Success Story"; "Helping Local Teachers Teach Health Education"; "Interaction of Drugs and Alcohol"; "Electrical Safety in Office and Hospital"; "Giving Support to the Dying"; "Walter Reed as a Frontier Surgeon"; "What Emergency Facilities Should Be Available in Your Hospital?"; and "Proper Use vs. Abuse of Oxygen."

Elective small-group discussions will consider such diverse topics as techniques of pregnancy termination, problems in psychiatry, dermatitis, pulmonary embolism, diabetes and blindness, blood lipid disorders, hair transplantation, preceptorships in medical education, paroxysmal tachycardia, dizziness and vertigo, and stroke rehabilitation.

Course is sponsored by U of I College of Medicine, Department of Family Practice, and Iowa Academy of Family Physicians. For information on registration, write: Director, Office of Continuing Medical Education, The University of Iowa, Iowa City, IA 52242.

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

The Cardiac Arrhythmias. By Brendan Phibbs, MD. Second Edition, 1973. The C V Mosby Co, St Louis, Mo. Pp 205. Price: $7.50

Cancer Diagnosis in Children. By L D Samuels, MD. The Chemical Rubber Co, 18901 Cranwood Parkway, Cleveland, Ohio 44128. 1973. Pp 131. Price: $26.00

Haemopoietic Stem Cells. Ciba Foundation Symposium. Associated Scientific Publishers, P. O. Box 1270, Amsterdam. Pp 345.

Locomotion of Tissue Cells. Ciba Foundation Symposium. Associated Scientific Publishers, P. O. Box 1270, Amsterdam. Pp 380.

Questions and Answers on Contact Lens Practice. By Jack Hartstein, MD. Second Edition, 1973. The C V Mosby Co, St. Louis, Mo. Pp 254. Price: $12.75

Handbook of Ocular Therapeutics and Pharmacology. By Philip P Ellis, MD and Donn L Smith, MD. Fourth Edition, 1973. The C V Mosby Co, St Louis, Mo. Pp 262. Price: $14.75

Flexible Implant Resection Arthroplasty in the Hand and Extremities. By Alfred B Swanson, MD. The C V Mosby Co, St Louis, Mo, 1973. Pp 352. Price: $37.50

BOOK REVIEWS

Encyclopaedia of Occupational Health and Safety

McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, N. Y. 10020. 1972. 1621 pages. Two volumes. Price: $49.50

In my opinion, this encyclopedia has considerable value as a reference, especially in providing information needed in the day-to-day operation of a university facility, including the many experimental laboratories existing on a campus of a large or even a small university. I recognize that there is medical information included in this reference which is directed more or less primarily to professional personnel. However, as the question of safety engineering and responsiveness to legal liabilities reaches into all phases of the campus, including the hospital and its many associated laboratories, this material is very useful even though some of its aspects may be beyond the full understanding of a lay person. Since having this reference for a short period, I have referred to this encyclopedia and find it quite useful in answering certain questions relating to chemicals and their toxicity and preventative measures to be taken. While similar information is available from other references, the material does identify the hazard and provide safety and health measures.

I am impressed with the format and presentation of the material included and the qualifications of the authors of each of the subjects covered. It will be of interest to me to see how this reference is accepted as authoritative in establishing the proof of an issue involving litigation on a loss resulting from an accident. Obviously there are some conflicts in the information given with standards presently adopted and followed in this country, but as with any other reference material, such conflicts may narrow somewhat, but not appreciably, the applicability of this reference to the United States.—Earl V. Rupp, BS, MBA, JD

CONTRIBUTIONS—CES FOUNDATION
October 1973

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1973:

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Marshfield Clinic; Marshfield Clinic Foundation — *Drug Exhibit*

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THE ACADEMY OF MEDICAL HISTORY of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues are only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, N J 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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